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|---------------------------------|---|-------------------------------|---|
| <i>SERFF Tracking Number:</i> | <i>AGDE-126006827</i> | <i>State:</i> | <i>Arkansas</i> |
| <i>Filing Company:</i> | <i>National Union Fire Insurance Company of Pittsburgh, PA</i> | <i>State Tracking Number:</i> | <i>41906</i> |
| <i>Company Tracking Number:</i> | <i>V40004NUFIC(REV 01/09)/V40005NUFIC</i> | | |
| <i>TOI:</i> | <i>H04 Health - Blanket Accident/Sickness</i> | <i>Sub-TOI:</i> | <i>H04.000 Health - Blanket Accident/Sickness</i> |
| <i>Product Name:</i> | <i>Blanket Accident and Sickness</i> | | |
| <i>Project Name/Number:</i> | <i>Speciality Market Blanket A&S/V40004NUFIC(Rev 01/09)/V40005NUFIC</i> | | |

Filing at a Glance

| | | | |
|--|---|-------------------------------------|--|
| Company: National Union Fire Insurance Company of Pittsburgh, PA | | | |
| Product Name: Blanket Accident and Sickness | SERFF Tr Num: AGDE-126006827 | State: ArkansasLH | |
| TOI: H04 Health - Blanket Accident/Sickness | SERFF Status: Closed | State Tr Num: 41906 | |
| Sub-TOI: H04.000 Health - Blanket Accident/Sickness | Co Tr Num: V40004NUFIC(REV 01/09)/V40005NUFIC | State Status: Approved-Closed | |
| Filing Type: Form | Co Status: | Reviewer(s): Rosalind Minor | |
| | Authors: Wanda Floyd, Elaine Showstead | Disposition Date: 01/29/2009 | |
| | Date Submitted: 01/27/2009 | Disposition Status: Approved-Closed | |
| Implementation Date Requested: On Approval | | Implementation Date: | |
| State Filing Description: | | | |

General Information

| | |
|--|---|
| Project Name: Speciality Market Blanket A&S | Status of Filing in Domicile: Authorized |
| Project Number: V40004NUFIC(Rev 01/09)/V40005NUFIC | Date Approved in Domicile: 08/19/2008 |
| Requested Filing Mode: Review & Approval | Domicile Status Comments: These forms are exempt from filing in our domicilliary state of Pennsylvania. They were place in use on August 19, 2008 |
| Explanation for Combination/Other: | Market Type: Group |
| Submission Type: New Submission | Group Market Size: Small and Large |
| Overall Rate Impact: | Group Market Type: Blanket |
| Filing Status Changed: 01/29/2009 | |
| State Status Changed: 01/29/2009 | Deemer Date: |
| Corresponding Filing Tracking Number: V40004NUFIC(Rev 01/09)/V40005NUFIC | |
| Filing Description: | |

| | | | |
|---------------------------------|---|-------------------------------|---|
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| <i>Project Name/Number:</i> | <i>Speciality Market Blanket A&S/V40004NUFIC(Rev 01/09)/V40005NUFIC</i> | | |

National Union Fire Insurance Company of Pittsburgh, Pa. hereby submits for your review and approval, copies of the above captioned forms. These forms are new and are being filed to replace policy forms V30028AR/V30029AR et al, which were filed and approved by your department on September 12, 2000. Subsequent additions and/or changes were further approved on May 7, 2001, March 31, 2003, May 4, 2004, and February 15, 2005.

The above captioned forms will provide blanket accident and sickness insurance primarily for non-profit emergency service organizations such as volunteer firemen and rescue units, pursuant to 23-86-101 (6) of the Arkansas Insurance Code. Coverage will be provided to eligible residents of Arkansas through an out-of-state policy which has been filed and approved in the state of Delaware on September 3, 2008. Premium is paid by the organization and coverage is provided to all eligible members as defined in the Policy.

PLEASE SEE OUR SUBMISSION LETTER ATTACHED IN THE "SUPPORTING DOCUMENT" SECTION

Company and Contact

Filing Contact Information

| | |
|---|---|
| Elaine Showstead, Senior A&H Regulatory Affairs Analyst 600 King Street Wilmington, DE 19801 | elaine.showstead@aig.com (800) 225-5244 [Phone] (302) 594-4810[FAX] |
|---|---|

Filing Company Information

| | | |
|---|--|--|
| National Union Fire Insurance Company of Pittsburgh, PA 70 Pine Street New York, NY 10270 (212) 770-7000 ext. [Phone] | CoCode: 19445 Group Code: 12 Group Name: AIG FEIN Number: 25-0687550 ----- | State of Domicile: Pennsylvania Company Type: State ID Number: |
|---|--|--|

Filing Fees

| | |
|---------------|---------|
| Fee Required? | Yes |
| Fee Amount: | \$50.00 |
| Retaliatory? | No |

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|---------------------------------|---|-------------------------------|---|
| <i>SERFF Tracking Number:</i> | <i>AGDE-126006827</i> | <i>State:</i> | <i>Arkansas</i> |
| <i>Filing Company:</i> | <i>National Union Fire Insurance Company of Pittsburgh, PA</i> | <i>State Tracking Number:</i> | <i>41906</i> |
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| <i>TOI:</i> | <i>H04 Health - Blanket Accident/Sickness</i> | <i>Sub-TOI:</i> | <i>H04.000 Health - Blanket Accident/Sickness</i> |
| <i>Product Name:</i> | <i>Blanket Accident and Sickness</i> | | |
| <i>Project Name/Number:</i> | <i>Speciality Market Blanket A&S/V40004NUFIC(Rev 01/09)/V40005NUFIC</i> | | |
| Fee Explanation: | \$50.00 per package | | |
| Per Company: | No | | |

SERFF Tracking Number: AGDE-126006827 *State:* Arkansas
Filing Company: National Union Fire Insurance Company of *State Tracking Number:* 41906
Pittsburgh, PA
Company Tracking Number: V40004NUFIC(REV 01/09)/V40005NUFIC
TOI: H04 Health - Blanket Accident/Sickness *Sub-TOI:* H04.000 Health - Blanket Accident/Sickness
Product Name: Blanket Accident and Sickness
Project Name/Number: Speciality Market Blanket A&S/V40004NUFIC(Rev 01/09)/V40005NUFIC

| COMPANY | AMOUNT | DATE PROCESSED | TRANSACTION # |
|--|---------|----------------|---------------|
| National Union Fire Insurance Company of Pittsburgh, PA | \$50.00 | 01/27/2009 | 25303254 |

SERFF Tracking Number: AGDE-126006827 *State:* Arkansas
Filing Company: National Union Fire Insurance Company of
Pittsburgh, PA *State Tracking Number:* 41906
Company Tracking Number: V40004NUFIC(REV 01/09)/V40005NUFIC
TOI: H04 Health - Blanket Accident/Sickness *Sub-TOI:* H04.000 Health - Blanket Accident/Sickness
Product Name: Blanket Accident and Sickness
Project Name/Number: Speciality Market Blanket A&S/V40004NUFIC(Rev 01/09)/V40005NUFIC

Correspondence Summary

Dispositions

| Status | Created By | Created On | Date Submitted |
|-----------------|----------------|------------|----------------|
| Approved-Closed | Rosalind Minor | 01/29/2009 | 01/29/2009 |

SERFF Tracking Number: AGDE-126006827 *State:* Arkansas
Filing Company: National Union Fire Insurance Company of *State Tracking Number:* 41906
Pittsburgh, PA
Company Tracking Number: V40004NUFIC(REV 01/09)/V40005NUFIC
TOI: H04 Health - Blanket Accident/Sickness *Sub-TOI:* H04.000 Health - Blanket Accident/Sickness
Product Name: Blanket Accident and Sickness
Project Name/Number: Speciality Market Blanket A&S/V40004NUFIC(Rev 01/09)/V40005NUFIC

Disposition

Disposition Date: 01/29/2009

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: AGDE-126006827 State: Arkansas

Filing Company: National Union Fire Insurance Company of Pittsburgh, PA State Tracking Number: 41906

Company Tracking Number: V40004NUFIC(REV 01/09)/V40005NUFIC

TOI: H04 Health - Blanket Accident/Sickness Sub-TOI: H04.000 Health - Blanket Accident/Sickness

Product Name: Blanket Accident and Sickness

Project Name/Number: Speciality Market Blanket A&S/V40004NUFIC(Rev 01/09)/V40005NUFIC

| Item Type | Item Name | Item Status | Public Access |
|---------------------|--|-----------------|---------------|
| Supporting Document | Flesch Certification | Approved-Closed | Yes |
| Supporting Document | Application | Approved-Closed | Yes |
| Supporting Document | Coverage Territory Endorsement | Approved-Closed | Yes |
| Supporting Document | Cover letter | Approved-Closed | Yes |
| Form | Summary of Coverage (Volunteers Members) | Approved-Closed | Yes |
| Form | Summary of Coverage (Career Members) | Approved-Closed | Yes |
| Form | Application for Blanket Accient and Sickness | Approved-Closed | Yes |
| Form | Participating Organization Endorsement | Approved-Closed | Yes |
| Form | Policy/Summary of Coverge Amendment | Approved-Closed | Yes |
| Form | Career Personnel Rider | Approved-Closed | Yes |
| Form | Auxiliary Police Endorsement | Approved-Closed | Yes |
| Form | Fire Dept w/Auxiliary Police Endorsement | Approved-Closed | Yes |
| Form | Optional Ben for Organized Team Sports Rider | Approved-Closed | Yes |
| Form | Optional Ben for Special Events Rider | Approved-Closed | Yes |
| Form | Optional Subrogation Rider | Approved-Closed | Yes |
| Form | Payment of Claims Rider | Approved-Closed | Yes |
| Form | Amendatory Endorsement (Volunteer Members) | Approved-Closed | Yes |
| Form | Amendatory Endorsement (Career Members) | Approved-Closed | Yes |
| Form | Continuation of Hlth Ins Prem Ben Rider (Career Members) | Approved-Closed | Yes |

SERFF Tracking Number: AGDE-126006827 State: Arkansas

Filing Company: National Union Fire Insurance Company of Pittsburgh, PA State Tracking Number: 41906

Company Tracking Number: V40004NUFIC(Rev 01/09)/V40005NUFIC

TOI: H04 Health - Blanket Accident/Sickness Sub-TOI: H04.000 Health - Blanket Accident/Sickness

Product Name: Blanket Accident and Sickness

Project Name/Number: Speciality Market Blanket A&S/V40004NUFIC(Rev 01/09)/V40005NUFIC

Form Schedule

Lead Form Number: V40004NUFIC(Rev 01/09)/V40005NUFIC

| Review Status | Form Number | Form Type | Form Name | Action | Action Specific Data | Readability | Attachment |
|-----------------|------------------------|--|---|---------|----------------------|-------------|----------------------------|
| Approved-Closed | V40004NUFIC(Rev 01/09) | Other | Summary of Coverage (Volunteers Members) | Initial | | 50 | V40004NUFIC(Rev 01-09).pdf |
| Approved-Closed | V40005NUFIC | Other | Summary of Coverage (Career Members) | Initial | | 50 | V40005NUFIC(Rev 0109).pdf |
| Approved-Closed | V40002NUFIC-AR | Application/Enrollment Form | Application for Blanket Accident and Sickness | Initial | | 0 | V40002NUFIC-AR.pdf |
| Approved-Closed | V40003NUFIC | Policy/Contract/Fraternity Certificate: Amendment, Insert Page, Endorsement or Rider | Participating Organization Endorsement | Initial | | 51 | V40003NUFIC.pdf |
| Approved-Closed | V40006NUFIC | Policy/Contract/Fraternity Certificate: Amendment, Insert Page, Endorsement or Rider | Policy/Summary of Coverage Amendment | Initial | | 51 | V40006NUFIC.pdf |
| Approved-Closed | V40007NUFIC(Rev 01/09) | Policy/Contract/Fraternity | Career Personnel Rider | Initial | | 52 | V40007NUFIC(Rev 01-09).pdf |

SERFF Tracking Number: AGDE-126006827 State: Arkansas
 Filing Company: National Union Fire Insurance Company of Pittsburgh, PA State Tracking Number: 41906
 Company Tracking Number: V40004NUFIC(REV 01/09)/V40005NUFIC
 TOI: H04 Health - Blanket Accident/Sickness Sub-TOI: H04.000 Health - Blanket Accident/Sickness
 Product Name: Blanket Accident and Sickness
 Project Name/Number: Speciality Market Blanket A&S/V40004NUFIC(Rev 01/09)/V40005NUFIC

Certificate:
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|---------------------|-----------------|--|---------|----|---------------------|
| Approved- Closed | V40008NU FIC | Policy/Cont Auxiliary Police ract/Fratern Endorsement | Initial | 51 | V40008NUFI C.pdf |
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|---------------------|-----------------|--|---------|----|---------------------|
| Approved- Closed | V40009NU FIC | Policy/Cont Fire Dept w/Auxiliary ract/Fratern Police Endorsement | Initial | 50 | V40009NUFI C.pdf |
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| Approved- Closed | V40010NU FIC(Rev 01/09) | Policy/Cont Optional Ben for ract/Fratern Organized Team al Sports Rider | Initial | 50 | V40010NUFI C(Rev 01- 09).pdf |
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| Approved- Closed | V40011NU FIC(Rev 01/09) | Policy/Cont Optional Ben for ract/Fratern Special Events Rider al | Initial | 50 | V40011NUFI C(Rev 01- 09).pdf |
|---------------------|-------------------------------|---|---------|----|------------------------------------|

Certificate:

| Approval Status | Form Number | Description | Page Count | File Name |
|-----------------|----------------|--|------------|--------------------|
| Approved-Closed | V40012NUFIC | Policy/Cont Optional Subrogation Initial ract/Fratern Rider al Certificate: Amendmen t, Insert Page, Endorseme nt or Rider | 57 | V40012NUFIC.pdf |
| Approved-Closed | V40013NUFIC | Policy/Cont Payment of Claims Initial ract/Fratern Rider al Certificate: Amendmen t, Insert Page, Endorseme nt or Rider | 55 | V40013NUFIC.pdf |
| Approved-Closed | V40018NUFIC-AR | Policy/Cont Amendatory Initial ract/Fratern Endorsement al (Volunteer Members) Certificate: Amendmen t, Insert Page, Endorseme nt or Rider | 54 | V40018NUFIC-AR.pdf |
| Approved-Closed | V40019NUFIC-AR | Policy/Cont Amendatory Initial ract/Fratern Endorsement al (Career Members) Certificate: Amendmen | 52 | V40019NUFIC-AR.pdf |

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| <i>Product Name:</i> | <i>Blanket Accident and Sickness</i> | | |
| <i>Project Name/Number:</i> | <i>Speciality Market Blanket A&S/V40004NUFIC(Rev 01/09)/V40005NUFIC</i> | | |
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AIG Domestic Accident & Health Division

A Division of the AIG Companies®

NATIONAL UNION FIRE INSURANCE COMPANY OF PITTSBURGH, PA.

Executive Offices: 70 Pine Street, New York, NY 10270

(212) 770-7000

(a capital stock company, herein referred to as the Company)

This summary of coverage furnished by National Union Fire Insurance Company describes the coverage that will be provided for all those persons called **Insured Persons** as defined in this summary of coverage. Coverage will be provided for losses described herein subject to the terms of the Master Policy (called "the policy" in this summary of coverage). This summary of coverage is issued to the **Policyholder** named in the **Schedule**.

The coverage provided under this summary of coverage is valid only when the required premium due as shown in the **Schedule** has been paid. The complete terms and conditions governing each **Insured Person's** coverage are in the policy issued to the **Policyholder** named in the **Schedule**. The policy may be changed or terminated without consent of or notice to each **Insured Person**.

CONSIDERATION – TERM

Coverage under the policy is provided in consideration of the payment of the premium by the **Policyholder**. The premium due is shown in the **Schedule**. The term of coverage for such **Policyholder** will begin on the Policy Effective Date and end on the Policy Termination Date as shown in the **Schedule**. All periods of insurance will begin and end at 12:01 AM Standard Time at the address of the **Policyholder**.

RENEWAL

Coverage may be renewed by **Us** for further consecutive terms by the payment of **Our** premium rate in effect at the time of renewal. If this coverage is not renewed, insurance will stop on the date to which premiums have been paid subject to the Grace Period provisions.

INDIVIDUAL EFFECTIVE AND TERMINATION DATES

Coverage for an **Insured Person** will take effect on the later of: (1) the Policy Effective Date shown in the **Schedule**; or (2) the date he or she becomes an **Insured Person** as defined in this summary of coverage.

Coverage for an **Insured Person** will end on the earliest of: (1) the date the policy terminates; (2) the date he or she is no longer an **Insured Person** as defined in this summary of coverage; or (3) the date the **Policyholder's** coverage ends.

Termination of coverage will not affect any loss resulting from participation in a **Covered Activity** when such participation occurred prior to the date of termination.

The President and Secretary of National Union Fire Insurance Company of Pittsburgh, Pa. witness this summary of coverage:

President

Secretary

PLEASE READ THIS SUMMARY OF COVERAGE CAREFULLY.

TABLE OF CONTENTS

Schedule of Coverages[X]

Definitions.....[X]

Benefits

- Loss of Life Benefits[X]
- Lump Sum Living Benefits[X]
- Weekly Income Benefits.....[X]
- Occupational Retraining Benefits.....[X]
- Weekly Injury Permanent Impairment Benefit.....[X]
- Optional Weekly Injury Permanent Impairment COLA Benefit.....[X]
- Medical Expense Benefits.....[X]
- Continuation of Health Insurance Premium Benefit[X]
- Transition Benefit.....[X]
- Felonious Assault Benefit.....[X]
- Home Alteration and Vehicle Modification Benefit[X]
- Optional Benefits[X]

Exclusions[X]

General Provisions.....[X]

SCHEDULE OF COVERAGES

Policyholder:

Policy Number VFP:

Participating Organization:
(Name and Address)

Policy Effective Date:

Term:

Policy Termination Date:

Premium: \$

This summary of coverage provides only those following benefits that have a specified amount entered opposite the name of the benefit. Benefits that are followed by entry of the word "none" are not provided.

PART COVERAGE

AMOUNT OF INSURANCE

I. Loss of Life Benefits

A. Accidental Death Benefits

(1) Accidental Death Indemnity Benefit [\$]

(2) Seat Belt Benefit Amount [\$]

B. Illness Loss of Life Benefit [\$]

C. Dependent Child Benefit Amount [\$10,000]

D. Spousal Support Benefit Amount [\$5,000]

E. Memorial Benefit Amount [\$2,000]

II. Lump Sum Living Benefits

A. Accidental Dismemberment Principal Sum [\$]

B. Vision Impairment Benefit [\$]

C. Injury Permanent Impairment Benefit Principal Sum [\$]

D. Heart Permanent Impairment Benefit Principal Sum [\$]

E. Illness Permanent Impairment Benefit Principal Sum [\$]

F. Cosmetic Disfigurement Resulting From Burns Principal Sum [\$]

G. HIV Positive Lump Sum Benefit [\$]

III. Weekly Income Benefits

A. Total Disability Benefits

(1) Total Disability Weekly Income Benefit (first 28 days) [\$]

(2) Total Disability Maximum Weekly Amount (after 28 days) [\$]

(3) Total Disability Minimum Weekly Amount [\$]

B. Partial Disability Benefits

(1) Partial Disability Weekly Income Benefit (first 28 days) [50%/\$]

(2) Partial Disability Maximum Weekly Amount (after 28 days) [50%/\$]

(3) Partial Disability Minimum Weekly Amount [50%/\$]

IV. Occupational Retraining Benefit Maximum Amount [\$20,000]

V. Weekly Injury Permanent Impairment Benefit [\$]

VI. Optional Weekly Injury Permanent Impairment COLA Benefit ☐ Yes ☐ No

VII. Medical Expense Benefits

- A. Medical Expense Maximum Amount..... [\\$]
 Medical Expense Benefit Options
 (1) Excess of Workers' Compensation or No-Fault Auto Insurance Benefits ☐
 (2) Excess of Workers' Compensation, No-Fault Auto Insurance and Other Group Insurance ☐
 (3) Primary Medical Expense Benefit ☐
 B. Cosmetic Plastic Surgery Maximum Amount..... [\$10,000]
 C. Post Traumatic Stress Disorder Maximum Amount..... [\$10,000]
 D. Critical Incident Stress Management Maximum Amount (Per Covered Activity)..... [\$2,500]
 E. Family Expense Benefit [\\$]

VIII. Continuation Of Health Insurance Premium Benefit Maximum Amount [\\$]

IX. Transition Benefit ☐ Yes ☐ No

X. Felonious Assault Benefit..... ☐ Yes ☐ No

XI. Home Alteration and Vehicle Modification Benefit Maximum Amount..... [\$15,000]

XII. Optional Benefits

- A. Weekly Hospital Indemnity Benefit [\\$]
 B. Additional Disability Weekly Benefit [\\$]
 C. Extended Total Disability Benefit ☐ Yes ☐ No
 D. 24-Hour Accidental Death and Dismemberment Benefit..... [\\$]
 E. Off-Duty Activity Accidental Death and Dismemberment Benefit..... [\\$]

POLICY FORMS ATTACHED AT ISSUANCE:

| | |
|--------------|--|
| [V40007NUFIC | Career Personnel Rider |
| V40008NUFIC | Auxiliary Police Endorsement |
| V40009NUFIC | Fire Departments With Auxiliary Police Endorsement |
| V40010NUFIC | Optional Benefits For Organized Team Sports Rider |
| V40011NUFIC | Optional Benefits For Special Events Rider |
| V40012NUFIC | Optional Subrogation Rider |
| V40013NUFIC | Payment of Claims Rider |
| V40014NUFIC | Domestic Partner Endorsement |
| V40015NUFIC | Civil Unions Partner Endorsement |
| 89644 (7/05) | Coverage Territory Endorsement (OFAC) |
| V40006NUFIC | Amendatory Endorsement # [X] |

[ADDITIONAL ENTITIES:

[ABC Fire Company]]

DEFINITIONS

(Additional defined terms can be found throughout this summary of coverage)

Any capitalized terms in the policy, application, this summary of coverage, and any riders, endorsements, amendments or other attached papers are to be given the meanings as ascribed in this section or as later defined.

Average Weekly Wage – means an average weekly wage determined by the greater of: (1) the total of wages, salaries, tips, or unemployment compensation for the calendar year immediately preceding the year in which the loss occurred; (2) the average weekly wage earned in the 12 months preceding the loss; (3) the annualized weekly wage earned in the three months preceding the loss; or (4) for the self-employed, the amount taken from Schedule C, E, or F which is reported on IRS Form 1040 as net taxable income, excluding rental, investment or passive income. The **Average Weekly Wage** will be verified by the **Insured Person's** employer and/or tax records.

Consumer Price Index – means the consumer price index published by the U.S. Department of Labor's Bureau of Labor Statistics for All Urban Consumers, All Items (CPI-U).

Covered Activity – means any activity, including travel directly to and from such activity, which is a normal duty of an **Insured Person**, including any: (1) emergency response for fire suppression and rescue or emergency medical activity; (2) training exercise which simulates an emergency and where active physical participation is required; (3) **Firematic Events or Contests**; (4) class room training; (5) fund-raising activities including athletic activities solely for the purpose of raising funds for the **Policyholder** or other non-profit organization when such fund-raising is performed as an activity of the **Policyholder**, except any activity in football, ice or field hockey, lacrosse, soccer or boxing; (6) official functions attended primarily by members of the **Policyholder** for which the purpose is to further the business of the **Policyholder** (i.e. installation dinners, banquets, etc.); (7) official conventions, conferences or meetings of emergency fire, rescue or medical personnel attended by the **Insured Person** on behalf of the **Policyholder** including personal travel or activities undertaken attendant to such convention, conference or meeting; and (8) participation in pre-approved covered athletic events or programs conducted on the premises of the **Policyholder**. Under no circumstances is there coverage for participation in the athletic events listed in Exclusion number 9.

The **Covered Activity** must be performed at the direction, or with the knowledge, of an officer of the **Policyholder**, unless immediate action is required of the **Insured Person** at the scene of an emergency not on behalf of the **Policyholder** or any other organization.

Firematic Events or Contests – means practice or participation in an organized event intended to enhance the **Insured Person's** skills or emergency reaction times. These events include, but are not limited to, departmental or interdepartmental: (1) apparatus pumping contests; (2) battle of the barrel; (3) antique pumping; (4) hose rolling contests; (5) equipment donning contests; (6) bucket brigades; (7) ladder climbs; (8) tug of war contests; and (9) apparatus operation rodeos.

Gainful Occupation – means an occupation for which an **Insured Person** is qualified by reason of education, training or experience, which has a reasonable expectation to provide more than 85% of pre-disability earnings.

Hospital - means a facility which: (1) is operated according to law for the care and treatment of injured and sick people; (2) has organized facilities for diagnosis and surgery on its premises or in facilities available to it on a prearranged basis; (3) has 24 hour nursing service by registered nurses (R.N.'s); and (4) is supervised by one or more Physicians. A Hospital does not include: (1) a nursing, convalescent or geriatric unit of a hospital when a patient is confined mainly to receive nursing care; or (2) a facility which is, other than incidentally, a rest home, nursing home, convalescent home or home for the aged; nor does it include any ward, room, wing, or other section of the hospital that is used for such purposes.

Illness – means any disease, sickness, or infection of an **Insured Person** while coverage under the policy is in force as to the **Insured Person**. The **Illness** must: (1) manifest itself during a specific **Covered Activity** with the result that the **Insured Person** interrupts his or her participation in such **Covered Activity** in order to receive immediate medical treatment; or (2) directly result from participation in a **Covered Activity** and also result in the **Insured Person** receiving medical treatment within 48 hours of participation in such **Covered Activity**. The requirement that medical treatment be received within 48 hours is waived for **Infectious Diseases**. Medical treatment means treatment by a **Physician** or at a **Hospital** for the **Illness**.

Immediate Family Member – means the **Insured Person's** spouse, child, parent, brother or sister.

Infectious Disease – means a disease included within the list of potentially life-threatening infectious diseases, developed by the Secretary of Health and Human Services, pursuant to Title XXVI of the Public Health Service Act, such as hepatitis, clostridium, rubella and tuberculosis.

Injury(ies) – means accidental bodily injury sustained by the **Insured Person**: (1) during and resulting from an **Insured Person's** participation in a specific **Covered Activity** while coverage under the policy is in force as to the **Insured Person**; (2) which directly (independent of sickness, disease, mental incapacity or any other cause) causes a loss to the **Insured Person**; and (3) which is not otherwise defined as an **Illness**. The term **Injury**, for the purposes of this policy, shall not include human immunodeficiency virus (HIV), acquired immune deficiency syndrome (AIDS) or AIDS related complex (ARC), or any heart or circulatory malfunction.

Insured Person(s) – means any officially designated member of the **Policyholder** while acting as: (1) a volunteer member for the **Policyholder**; (2) any junior member or member in training; (3) any commissioner, director, trustee or other similar position associated with the **Policyholder**; (4) any bystander deputized at the time of the emergency by an official of the **Policyholder** to assist in an emergency, but only during the actual emergency; (5) any auxiliary member; (6) any non-member who is requested to participate by the auxiliary or **Policyholder**; and (7) any member who receives remuneration for “on call” duty or out of pocket expenses subject to the following:

An **Insured Person** will not include a member who looks to the **Policyholder** for his or her primary source of income while acting within the scope of his or her employment unless the policy is specifically endorsed to provide coverage for career members. A member will be deemed to look to the **Policyholder** for his or her primary source of income if he or she: (1) averages [25] hours or more employment per week; or (2) are salaried and works a schedule of more than [25] hours per week. The time frame used to determine the average hours or the salaried schedule will be the same time frame used to calculate the **Average Weekly Wage**.

Other Valid and Collectible Insurance – means any: (1) group plan, program, or insurance policy; (2) any other group hospital, surgical or medical benefit plan; (3) union welfare plans or group employer or employee benefit programs; or (4) any no-fault automobile insurance plan or similar law. **Other Valid and Collectible Insurance** will not include benefits provided by the United States Social Security Act or any individual disability insurance plans.

Out-Patient Physical Therapy – means rehabilitative physical therapy which is: (1) received without being confined overnight in a **Hospital** as a registered bed patient; (2) an approved therapy program; (3) necessary for the rehabilitation of an **Insured Person** from an **Injury** or an **Illness** for which he or she was confined in a **Hospital** for treatment; (4) administered by a licensed physical therapist; and (5) monitored by a **Physician**.

Partial Disability, Partially Disabled – means, for an **Insured Person** with an occupation producing wages as described in the definition of **Average Weekly Wage**, the inability to perform one or more, but not all, of the material and substantial duties of his or her own occupation. If the **Insured Person** does not have an occupation producing wages as described in the definition of **Average Weekly Wage**, **Partial Disability**,

Partially Disabled means: (1) the inability to perform one or more, but not all, of the material and substantial duties of an occupation for which the **Insured Person** is qualified by reason of education, training, or experience; or (2) the inability to perform one or more, but not all, of the regular activities of the **Insured Person**. The **Insured Person** must be under the regular care of a **Physician** during **Partial Disability**.

Permanent Impairment - means a medical condition which is a physical or functional abnormality or loss, which remains after the maximum medical rehabilitation has been achieved, and which is considered stable or non-progressive by the **Physician** at the time an evaluation is made.

Physician – means any duly licensed medical practitioner: (1) who is acting within the scope of his or her license; and (2) who is not the **Insured Person** or an **Immediate Family Member**.

Policyholder – means a non-profit emergency service organization or municipality or political subdivision that elects coverage under the policy and pays the required premium. The **Policyholder** is named in the **Schedule**. Coverage for such **Policyholder** will be in force at 12:01 A.M. on the Policy Effective Date shown in the **Schedule** subject to payment of the required premium. Coverage is limited to **Insured Persons** of any fire, emergency, rescue or ambulance department of the municipality or political subdivision.

Post Traumatic Stress Disorder – means emotional stress resulting from a **Traumatic Incident** experienced by an **Insured Person** which adversely affects the psychological and physical well-being of the **Insured Person**.

Reasonable and Customary Expense – means an expense which: (1) is charged for treatment, supplies or medical services medically necessary to treat the **Insured Person's** condition; (2) does not exceed the usual level of charges for similar treatment, supplies or medical services in the locality where the expense is incurred; and (3) does not include charges that would not have been made if no insurance existed.

Schedule – means the Schedule of Coverages which is a part of this summary of coverage.

Total Disability, Totally Disabled – means, for an **Insured Person** with an occupation producing wages as described in the definition of **Average Weekly Wage**, the inability to perform all of the material and substantial duties of his or her own occupation. If the **Insured Person** does not have an occupation producing wages as described in the definition of **Average Weekly Wage**, **Total Disability, Totally Disabled** means: (1) the inability to perform all of the material and substantial duties of an occupation for which the **Insured Person** is qualified by reason of education, training, or experience; or (2) the inability to perform all of the regular activities of the **Insured Person**. The **Insured Person** must be under the regular care of a **Physician** during **Total Disability**.

Traumatic Incident – means an abnormal experience, outside the range of usual human experiences and includes, but is not limited to: (1) line-of-duty death or serious injury to other **Insured Person's**; (2) a single incident having multiple casualties; (3) death or serious injury of a child; and (4) dealing with victims known to the **Insured Person**.

We, Us, or Our refers to National Union Fire Insurance Company of Pittsburgh, Pa. **Our** Executive Offices are located at 70 Pine Street, New York, New York 10270.

PART I. LOSS OF LIFE BENEFITS

A. ACCIDENTAL DEATH BENEFITS

- (1) Accidental Death Indemnity Benefit. **We** will pay the Accidental Death Indemnity Benefit shown in the **Schedule** if **Injury** to an **Insured Person** results in the **Insured Person's** death.

(2) **Seat Belt Benefit.** If an **Accidental Death Indemnity Benefit** is payable hereunder and the accident which caused the **Insured Person's** accidental death occurred while the **Insured Person** was wearing a properly fastened automotive seat belt, **We** will pay an additional amount equal to the **Seat Belt Benefit Amount** shown in the **Schedule**. This **Seat Belt Benefit** is not payable for **Injuries** sustained by an **Insured Person** while standing inside or on the tailboard of any vehicle.

B. ILLNESS LOSS OF LIFE BENEFIT

We will pay the **Illness Loss of Life Benefit** shown in the **Schedule** if death to an **Insured Person**: (1) occurs during a specific **Covered Activity** and is not otherwise payable as an **Accidental Death Indemnity Benefit**; or (2) occurs due to an **Illness** covered as a result of participation in a specific **Covered Activity**. Either: (1) death; or (2) medical treatment for the **Illness** must occur within 48 hours of the **Covered Activity**. The requirement that death occurs or medical treatment for the **Illness** be received within 48 hours is waived for **Infectious Disease**. Medical treatment means treatment by a **Physician** or at a **Hospital** for the **Illness**.

No **Illness Loss of Life Benefit** will be payable if an **Accidental Death Indemnity Benefit** is payable under the policy, or if, as a direct result of participation in the same **Covered Activity**, an **HIV Positive Benefit** was paid to the **Insured Person** under the policy.

C. DEPENDENT CHILD BENEFIT

We will pay the **Dependent Child Benefit Amount** shown in the **Schedule** for each "Dependent Child" if either an **Accidental Death Indemnity Benefit** or an **Illness Loss of Life Benefit** is payable under the policy. **We** may make payment directly to the "Dependent Child's": (1) guardian; or (2) to an individual or institution with custody of the "Dependent Child" if; (a) the "Dependent Child" is a minor or is not competent to give a valid receipt for payment due him or her; and (b) no request for payment has been received by **Us** from a duly appointed guardian or other legally appointed representative. Payment made in this manner will release **Us** from all liability to the extent of any payment made.

"**Dependent Child**" means any unmarried child of the **Insured Person** who was dependent upon the **Insured Person** and either claimed on the **Insured Person's** final tax return, or was dependent as a result of a legally enforceable agreement filed with a court or other administrative body.

D. SPOUSAL SUPPORT BENEFIT

We will pay the **Spousal Support Benefit Amount** shown in the **Schedule** to the **Insured Person's** surviving spouse if either an **Accidental Death Indemnity Benefit** or an **Illness Loss of Life Benefit** is payable under the policy.

E. MEMORIAL BENEFIT

We will pay the **Memorial Benefit Amount** shown in the **Schedule** to the **Policyholder**, to be used to cover final expenses incurred by the **Policyholder** on behalf of the **Insured Person**, if either an **Accidental Death Indemnity Benefit** or an **Illness Loss of Life Benefit** is payable under the policy.

PART II. LUMP SUM LIVING BENEFITS

A. ACCIDENTAL DISMEMBERMENT BENEFIT

If **Injury** to an **Insured Person** shall result in a "Loss" listed below, **We** will pay the indicated percentage of the

Accidental Dismemberment Principal Sum shown in the **Schedule** for the “Loss” suffered. If the **Insured Person** suffers more than one “Loss” as a result of any one accident, only one amount, the largest, will be paid.

Accidental Dismemberment Chart

| <u>For Loss of:</u> | <u>% of Accidental Dismemberment Principal Sum Payable</u> |
|--|---|
| Both Hands or Both Feet | 100 |
| One Hand and One Foot..... | 100 |
| Entire Sight of Both Eyes | 100 |
| One Hand and Entire Sight of One Eye | 100 |
| One Foot and Entire Sight of One Eye..... | 100 |
| Speech and Hearing | 100 |
| One Arm or One Leg..... | 75 |
| Speech or Hearing | 50 |
| One Hand or One Foot..... | 50 |
| Entire Sight of One Eye..... | 50 |
| Both Thumbs | 10 |
| One Thumb | 5 |
| Each Joint of a Finger or Toe..... | 1 |

“**Loss**” means, with reference to the foot, a complete severance through or above the ankle joint; with reference to the hand, the complete severance of the distal, proximal or medial phalanx of four fingers; with reference to the arm or leg, the complete severance through or above the elbow or knee joint; with reference to the thumb, the complete severance at the metacarpophalangeal joint; and with reference to a joint of a finger or toe, the complete severance of a distal, proximal or (where applicable) medial phalanx. “**Loss**” of speech or hearing means the total and irrecoverable loss of speech and/or hearing. “**Loss**” of sight means the total and irrecoverable loss of sight.

B. VISION IMPAIRMENT BENEFIT

If **Injury** to an **Insured Person** shall result in “Permanent Damage” to the **Insured Person’s** eyesight, **We** will pay the indicated percentage of the Vision Impairment Benefit shown in the **Schedule**, for each impaired eye, based on the degree of vision impairment according to the Vision Impairment Chart shown below. This chart shall apply separately to each eye.

Vision Impairment Chart

| Vision Impairment | % of Vision Impairment Benefit Payable Per Each Eye |
|--------------------------|--|
| 20/20 | 0.00% |
| 20/30 | 2.75% |
| 20/40 | 5.50% |
| 20/50 | 8.25% |
| 20/60 | 11.00% |
| 20/80 | 16.50% |
| 20/100 | 22.00% |
| 20/120 | 28.00% |
| 20/150 | 36.00% |
| 20/180 | 44.50% |
| 20/200 or poorer | 50.00% |

If the sight of an eye is less than 20/20 before the “Permanent Damage”, **We** will pay a benefit based only upon the additional impairment due to the **Injury**. In no event will **We** pay both Accidental Dismemberment Benefits for a loss of sight and Vision Impairment Benefit for **Injury** to the same eye sustained while participating in the same **Covered Activity**.

Any Vision Impairment Benefit paid or payable hereunder will be in addition to any Accidental Dismemberment Benefit paid or payable under the policy. However, in no event will the total amount of benefits payable as a result of any one accident exceed 100% of the largest Principal Sum shown in the **Schedule** for these Benefits.

“**Permanent Damage**” means, with reference to the eyes, irreparable **Injury** which results in permanently impaired vision, but not in total and irrecoverable loss of sight.

C. INJURY PERMANENT IMPAIRMENT BENEFIT

We will pay the Injury Permanent Impairment Benefit shown in the **Schedule** if an **Insured Person** suffers a **Permanent Impairment** due to an **Injury** and the **Insured Person** participates in an approved physical rehabilitation program if his or her physical condition so warrants. In no event will an Injury Permanent Impairment Benefit be payable if the Heart Permanent Impairment Benefit or an Illness Permanent Impairment Benefit is paid or payable for any one **Injury** or **Illness** sustained while participating in the same **Covered Activity**.

To Determine the Benefit Payable

The **Insured Person's Permanent Impairment**, due to an **Injury**, will be assigned an impairment value by an examining **Physician**. This value will be expressed as a percentage in relation to the whole person. The impairment value will be determined by the most current edition of the American Medical Association's (AMA) “Guides to the Evaluation of Permanent Impairment”. This percentage value will be applied to the Injury Permanent Impairment Benefit Principal Sum shown in the **Schedule** to determine the Injury Permanent Impairment Benefit payable under the policy.

If, due to an **Injury**, the **Insured Person** has a **Permanent Impairment** rating of 90% or higher then the **Insured Person** will receive 125% of the Injury Permanent Impairment Benefit Principal Sum.

For example:

- (1) if a knee **Injury** resulted in an AMA guideline lower extremity impairment rating of 38%, which equates to 15% of the whole body, the benefit would be 15% of the Injury Permanent Impairment Benefit; or
- (2) if a combination of leg and back **Injuries** result in an AMA guideline whole person impairment rating of 12% and 17%, respectively, which equates to a combined whole person impairment rating of 27%, the benefit would be 27% of the Injury Permanent Impairment Benefit; or
- (3) if a fracture at the second cervical vertebra results in incomplete quadriplegia with an AMA guideline whole person impairment rating of 93%, the benefit would be increased to 125% of the Injury Permanent Impairment Benefit since the impairment rating is 90% or higher.

Any Injury Permanent Impairment Benefit paid or payable hereunder will be in addition to any Accidental Dismemberment Benefit or Vision Impairment Benefit paid or payable under the policy. However, in no event will the total amount of benefits payable as a result of any one accident exceed 100% of the largest Principal Sum shown in the **Schedule** for these benefits, unless the **Permanent Impairment** rating for an **Injury** is 90% or higher in which case 125% of the Principal Sum is payable.

If the **Insured Person** has an impairment prior to the time of **Injury**, the impairment value that represents the pre-existing condition will be deducted from the **Permanent Impairment** evaluation due to the **Injury** as described above.

D. HEART PERMANENT IMPAIRMENT BENEFIT

We will pay a Heart Permanent Impairment Benefit shown in the **Schedule** if the **Insured Person** has a "Heart Permanent Impairment" due to a heart condition that results in at least 26 weeks of **Total Disability**, based upon the degree of heart impairment according to the Heart Permanent Impairment Benefit Chart shown below. The Heart Permanent Impairment Chart shows the percentage of the Heart Permanent Impairment Benefit due.

To Determine the Benefit Payable

No more than nine months after the **Covered Activity**, the **Insured Person's** highest "Left Ventricular Ejection Fraction" and lowest "New York Heart Association Functional Classification" will be obtained and compared to the Heart Permanent Impairment Benefit Principal Sum shown in the **Schedule**. The ratings must result from evaluations performed after the **Covered Activity** date.

If the **Insured Person** had a "Left Ventricular Ejection Fraction" of 35% or lower prior to the **Covered Activity** date, no Heart Permanent Impairment Benefit is due.

Heart Permanent Impairment Benefit Chart

| Left Ventricular Ejection Fraction | New York Heart Association Functional Classification | Heart Permanent Impairment Benefit Due |
|------------------------------------|--|--|
| 26 to 30% function | Class II | 25% |
| 26 to 30% function | Class III or IV | 50% |
| 21 to 25% function | Class II or III | 50% |
| 21 to 25% function | Class IV | 75% |
| Less than 21% function | Class II or III | 75% |
| Less than 21% function | Class IV | 100% |

The benefit due is calculated by multiplying the percentage due and the Principal Sum. The benefit is further modified by the **Insured Person's** age on the date of the heart impairment, according to the following table:

- | | |
|------------------|------------------------------|
| • Age 40 or less | – 125% of the amount payable |
| • Age 41 to 65 | – 75% of the amount payable |
| • Age 66 or over | – 50% of the amount payable |

For example:

- (1) if a 30 year old (on the date of heart impairment) has a "Left Ventricular Ejection Fraction" of 17% and a "New York Heart Association Functional Classification" of Class IV, the benefit would be 100% of the Heart Permanent Impairment Benefit times 125% since the age is less than 40, for a total benefit of 125% of the Heart Permanent Impairment Benefit; or,
- (2) if a 55 year old (on the date of heart impairment) has a "Left Ventricular Ejection Fraction" of 19% and a "New York Heart Association Functional Classification" of Class IV, the benefit would be 100% of the Heart Permanent Impairment Benefit times 75% since the age is between 41 and 65, for a total benefit of 75% of the Heart Permanent Impairment Benefit; or,
- (3) if a 68 year old (on the date of heart impairment) has a "Left Ventricular Ejection Fraction" of 18% and a "New York Heart Association Functional" Classification of Class IV, the benefit would be 100% of the Heart Permanent Impairment Benefit times 50% since the age is 66 or over, for a total benefit of 50% of the Heart Permanent Impairment Benefit.

“Heart Permanent Impairment” means a medical condition which is a physical and functional abnormality or loss as a consequence of an **Insured Person** sustaining a heart impairment as a result of a **Covered Activity**, resulting in: (1) a “Left Ventricular Ejection Fraction” of 30% or less; and (2) a “New York Heart Association Functional Classification” of II, III, or IV; and (3) at least 26 weeks of **Total Disability**.

“Left Ventricular Ejection Fraction” means a clinically used measure of the percentage of blood the heart is able to eject from the left ventricle.

“New York Heart Association Functional Classification” is a standard measurement of how heart function affects activities of daily living. Below is a summary of the New York Heart Association Classification:

- I No symptoms and no limitation in ordinary physical activity.
- II Mild symptoms and slight limitation during ordinary activity. Comfortable at rest.
- III Marked limitation in activity due to symptoms, even during less-than-ordinary activity. Comfortable only at rest.
- IV Severe limitations. Experiences symptoms even while at rest.

E. ILLNESS PERMANENT IMPAIRMENT BENEFIT

We will pay the Illness Permanent Impairment Benefit shown in the **Schedule** if **Illness** to an **Insured Person** results in five years (260 weeks) of Total Disability Benefits.

To Determine the Benefit Payable

If the **Insured Person** is unable to return to his or her occupation after five years (260 weeks) of Total Disability Benefits, 50% of the Illness Permanent Impairment Benefit shown in the **Schedule** is payable. If the **Insured Person** is unable to return to any **Gainful Occupation** after five years (260 weeks) of Total Disability Benefits, 75% of the Illness Permanent Impairment Benefit shown in the **Schedule** is payable. If the **Insured Person** has been approved for Social Security disability benefits or, if not eligible for Social Security disability benefits, otherwise meets the eligibility criteria for Social Security disability benefits, 125% of the Illness Permanent Impairment Benefit as shown in the **Schedule** is payable.

The five year (260 week) period of **Total Disability** does not need to be consecutive weeks but must be payable as a result of one **Illness** sustained while participating in the same **Covered Activity**.

If an **Insured Person** has received a Heart Permanent Impairment Benefit and later becomes eligible for payment under this benefit for the same condition, the amount payable under this benefit is the Illness Permanent Impairment Amount shown in the **Schedule**, less the amount previously paid under the Heart Permanent Impairment Benefit. The percentage schedule as described in the first paragraph of this section will also apply to the total amount payable.

F. COSMETIC DISFIGUREMENT RESULTING FROM BURNS BENEFIT

We will pay the benefits under this provision if, as the result of **Injury**, an **Insured Person** suffers from a cosmetic disfigurement due to a burn that is classified as a full thickness or third degree burn.

To Determine the Benefit Payable

Any Cosmetic Disfigurement Resulting From Burns Benefit paid or payable under this benefit will be based on a percentage of the Cosmetic Disfigurement Resulting From Burns Principal Sum shown in the **Schedule** and depend on the area of the body which was burned. The benefit payable for any one loss is determined by the following formula:

- (1) First the area of the body that was burned is assigned an area classification factor by using the chart shown below. Each body part is assigned a classification relative to its visual exposure (i.e., the higher the classification, the more visual the exposure);
- (2) This area classification factor is multiplied by the percentage of body surface actually burned. The attending **Physician** will determine the percentage applicable to each burn. The chart below lists the maximum allowance percentage for body surface burned for each area classification;
- (3) Steps 1 and 2 will produce a numerical factor that will be multiplied by the Cosmetic Disfigurement Resulting From Burns Principal Sum to determine the percentage of the Cosmetic Disfigurement Resulting From Burns Principal Sum payable under this benefit. For example, by using the Cosmetic Burn Chart shown below:
 - (a) if the entire surface of the right hand and forearm were burned the benefit would be $5 \times 4.5\% = 22.5\%$ of the Cosmetic Disfigurement Resulting From Burns Principal Sum payable; or
 - (b) if 50% of the surface of the right hand and forearm were burned the benefit would be $5 \times 2.25\%$ (which is 50% of 4.5) = 11.25% of the Cosmetic Disfigurement Resulting From Burns Principal Sum payable.

The following is a burn chart from which benefits can be determined. This chart only represents the maximum percentage of the Cosmetic Disfigurement Resulting From Burns Principal Sum payable for any one covered loss. If the **Insured Person** suffers burns in more than one area as a result of any one accident, benefits will not exceed more than 100% of the Cosmetic Disfigurement Resulting From Burns Principal Sum.

Cosmetic Burn Chart

| Body Part | Area Classification | Maximum Allowable % for Area Surface Burned | Maximum % of Cosmetic Disfigurement Resulting from Burns Principal Sum |
|--------------------------------|----------------------------|--|---|
| Face, Neck, Head | 11 | 9.0% | 99.0% |
| Hand & Forearm (Right) | 5 | 4.5% | 22.5% |
| Hand & Forearm (Left) | 5 | 4.5% | 22.5% |
| Upper Arm (Right) | 3 | 4.5% | 13.5% |
| Upper Arm (Left) | 3 | 4.5% | 13.5% |
| Torso (Front) | 2 | 18.0% | 36.0% |
| Torso (Back) | 2 | 18.0% | 36.0% |
| Thigh (Right) | 1 | 9.0% | 9.0% |
| Thigh (Left) | 1 | 9.0% | 9.0% |
| Lower Leg (Right) (below knee) | 3 | 9.0% | 27.0% |
| Lower Leg (Left) (below knee) | 3 | 9.0% | 27.0% |

The percentage shown is based on 100% of the Body Part identified being burned. Please refer to the **Schedule** for the amount of the Cosmetic Disfigurement Resulting From Burns Principal Sum.

Any Cosmetic Disfigurement Resulting From Burns Benefit paid or payable hereunder will be in addition to any Accidental Dismemberment Benefit, Injury Permanent Impairment Benefit, Illness Permanent Impairment Benefit, or Heart Permanent Impairment Benefit paid or payable under the policy. However, in no event will the total amount of benefits payable as a result of any one accident exceed 100% of the largest Principal Sum shown in the **Schedule** for these benefits.

G. HIV POSITIVE LUMP SUM LIVING BENEFIT

We will pay the HIV Positive Lump Sum Living Benefit shown in the **Schedule** if, as a direct result of

participation in a specific **Covered Activity**, an **Insured Person** tests "HIV Positive".

In the event that an HIV Positive Lump Sum Living Benefit and (1) an Illness Loss of Life Benefit or (2) an Illness Permanent Impairment Benefit are both payable under the policy as a result of any one **Illness** sustained while participating in the same **Covered Activity**, only one benefit, the largest, will be paid.

"**HIV**" means human immunodeficiency virus.

"**HIV Positive**" means the presence of **HIV** antibodies in the blood of an **Insured Person** as substantiated through both a positive screening test (enzyme-linked immunosorbent assay, ELISA) and a positive supplemental test such as Western Blot. All such tests must be approved by the Food and Drug Administration (FDA) with the interpretation of positivity as specified by the manufacturer(s).

PART III. WEEKLY INCOME BENEFITS

A. TOTAL DISABILITY BENEFITS

- (1) If **Injury** or **Illness** to an **Insured Person** results in **Total Disability**, **We** will pay the Total Disability Weekly Income Benefit shown in the **Schedule** for the first 28 days of **Total Disability**.
- (2) If **Total Disability** continues beyond 28 days, **We** will pay 100% of the difference between the **Insured Person's Average Weekly Wage** and any disability income benefits received by the **Insured Person** from any Workers' Compensation act or similar law and **Other Valid and Collectible Insurance**, not to exceed the Total Disability Maximum Weekly Amount shown in the **Schedule**, for each week the **Insured Person** is **Totally Disabled** up to a maximum of five years (260 weeks).
- (3) The minimum benefit payable for **Total Disability** will be the Total Disability Minimum Weekly Amount shown in the **Schedule**.
- (4) If an **Insured Person** is approved for disability retirement or otherwise retires, all eligibility for **Total Disability** terminates on the effective date of such retirement.

B. PARTIAL DISABILITY BENEFITS

- (1) If **Injury** or **Illness** to an **Insured Person** results in **Partial Disability**, **We** will pay the Partial Disability Weekly Income Benefit shown in the **Schedule** for the first 28 days of **Partial Disability**.
- (2) If **Partial Disability** continues beyond 28 days, **We** will pay 50% of the difference between the **Insured Person's Average Weekly Wage** and any disability income benefits received by the **Insured Person** from any Workers' Compensation act or similar law and **Other Valid and Collectible Insurance**, not to exceed the Partial Disability Maximum Weekly Amount shown in the **Schedule**, for each week the **Insured Person** is **Partially Disabled** up to a maximum of 52 weeks.
- (3) The minimum benefit payable for **Partial Disability** will be the Partial Disability Minimum Weekly Amount shown in the **Schedule**.
- (4) If an **Insured Person** is approved for disability retirement or otherwise retires, all eligibility for **Partial Disability** terminates on the effective date of such retirement.

C. DISABILITY BENEFITS GENERAL

If an **Insured Person** is **Totally Disabled** or **Partially Disabled** for less than a week, **We** will pay 1/7 of

the benefit otherwise payable for each full day the **Insured Person** is so disabled.

The amount of Total Disability Benefits or Partial Disability Benefits payable to an **Insured Person** who is **Totally Disabled** or **Partially Disabled** may be increased after Total Disability Benefits or Partial Disability Benefits have been paid to that **Insured Person** for at least 52 consecutive weeks. The increase will equal the percentage increase, if any, in the **Consumer Price Index** for the preceding calendar year. The increase will apply to either the **Insured Person's Average Weekly Wage** at the time of the **Covered Activity** which caused the **Injury** or **Illness**, or to the Total Disability Benefit or Partial Disability Benefit, whichever results in the higher benefit to the **Insured Person**. Any increase in benefits will become effective on July 1 next following the 52 week benefit period. Successive annual increases, if any, on July 1 of each subsequent year will be compounded.

In the event that benefits are payable for both **Total Disability** and **Partial Disability** resulting from **Injury** or **Illness** sustained while participating in the same **Covered Activity**, the maximum benefit period for all benefits is five years (260 weeks).

Periods of **Total Disability** or **Partial Disability** separated by less than five years (260 weeks) will be considered one period of disability unless due to separate and unrelated causes.

PART IV. OCCUPATIONAL RETRAINING BENEFIT

We will pay for "Covered Retraining Expenses", up to the Occupational Retraining Benefit Maximum Amount shown in the **Schedule**, if, as a result of **Injury** or **Illness**, an **Insured Person** is not able to hold a **Gainful Occupation** and chooses to enroll in an institution of higher learning or professional or trade training program. The objective of any professional or trade training program must be to return the **Insured Person** to work in an occupation to which he/she is suited. The professional or trade training program must be agreed upon by **Us** and the **Insured Person**.

We will pay any "Covered Retraining Expenses" incurred by an **Insured Person** in excess of benefits paid or payable under any Worker's Compensation act or similar law, no fault automobile insurance or similar law, and any **Other Valid and Collectible Insurance**.

"**Covered Retraining Expenses**" includes, but is not limited to, expenses for tuition, books, and any other training materials required by the institution of higher learning or professional or trade training program.

PART V. WEEKLY INJURY PERMANENT IMPAIRMENT BENEFIT

We will pay a Weekly Injury Permanent Impairment Benefit if: (1) **Injury** to an **Insured Person** results in a **Permanent Impairment**; and (2) it is determined that the **Insured Person** has a whole person **Permanent Impairment** due to an **Injury**, percentage value of 50% or greater for purposes of the Injury Permanent Impairment Benefit. This Weekly Injury Permanent Impairment Benefit will begin on either the 261st week or 521st week if the Extended Total Disability Benefit is selected from the date of participation in the **Covered Activity** which caused the **Injury** and will continue to be paid for the remainder of the **Insured Person's** lifetime.

The Weekly Injury Permanent Impairment Benefit will be determined by multiplying the Weekly Income Benefit amount payable on the 29th day of **Total Disability**, as determined under the Weekly Income Benefits section of the policy, by the percentage value of the **Insured Person's Permanent Impairment**.

Example: If the Total Disability Weekly Income Benefit payable on the 29th day of **Total Disability** is \$600.00 and the **Insured Person's Permanent Impairment**, due to an **Injury**, percentage value

is 70%, the lifetime Weekly Injury Permanent Impairment Benefit would be \$420 per week (\$600 x 70% = \$420).

The **Permanent Impairment** rating due to an **Injury** used to determine the Weekly Injury Permanent Impairment Benefit is final upon initiation of Weekly Injury Permanent Impairment Benefits. Subsequent changes in the **Permanent Impairment** due to an **Injury** rating, if any, will not affect the Weekly Injury Permanent Impairment Benefits paid or payable.

Weekly Injury Permanent Impairment Benefits will be paid in addition to any benefits paid or payable under the policy.

PART VI. OPTIONAL WEEKLY INJURY PERMANENT IMPAIRMENT COLA BENEFIT

If this Optional Weekly Injury Permanent Impairment COLA Benefit is selected by the **Policyholder** as indicated in the **Schedule** and Weekly Injury Permanent Impairment Benefit becomes payable under the policy, the amount payable will be increased after benefits have been paid for at least 52 consecutive weeks. The percentage of increase will equal the increase in the **Consumer Price Index**. This increased benefit payment will begin on July 1, following the 52 week benefit period. Successive annual increases on July 1 of each year will be compounded.

PART VII. MEDICAL EXPENSE BENEFITS

A. MEDICAL EXPENSE BENEFIT

We will pay the **Reasonable and Customary Expenses** incurred by an **Insured Person** as a result of an **Injury** or **Illness** for necessary:

- (1) medical, **Hospital** or surgical treatment;
- (2) "Home Health Care";
- (3) nursing services prescribed and monitored by a **Physician**;
- (4) Post-exposure Prophylaxis Protocol (PEP) treatment, when such treatment is advised by the attending **Physician**;
- (5) **Infectious Disease** screening test(s); or
- (6) Post-exposure preventive inoculations as a result of participation in a **Covered Activity**.

We will pay the medical expense benefits subject to the **Policyholder's** choice of 1, 2, or 3 below:

- (1) If "1" in the **Schedule** is marked with an "X", **We** will pay any covered medical expenses incurred by an **Insured Person** in excess of benefits paid or payable under any Workers' Compensation act or similar law, or no fault automobile insurance plan or similar law. If benefits are not payable under the applicable Workers' Compensation act or similar law, but are covered under the policy, **We** will pay such benefits.
- (2) If "2" in the **Schedule** is marked with an "X", **We** will pay any covered medical expenses incurred by an **Insured Person** in excess of benefits paid or payable under any Workers' Compensation act or similar law, no fault automobile insurance plan or similar law, and any **Other Valid and Collectible Insurance**.
- (3) If "3" in the **Schedule** is marked with an "X", **We** will pay any covered medical expenses incurred by an **Insured Person** on a primary basis regardless of benefits paid or payable under any other group insurance, no fault automobile insurance plan or similar law, or any Workers' Compensation act or similar law.

All medical expense benefits will be paid subject to the terms and limits of each applicable part.

We will not pay more than the Medical Expense Maximum Amount shown in the **Schedule** for any one **Injury** or **Illness**.

“Home Health Care” means those nursing and other home health care services provided to an **Insured Person** in his or her place of residence. **Home Health Care** must be: (1) performed by a “Home Health Care Practitioner”; (2) in lieu of confinement in a **Hospital** or nursing facility; and (3) pursuant to the orders of the attending **Physician**. Such attending **Physician's** orders must be written and include a plan of care which must be reviewed and approved by the **Physician**.

“Home Health Care Practitioner” means a nurse, medical social worker, home health aide, physical therapist, or other medical practitioner. However, no provider will be considered a **Home Health Care Practitioner** unless such practitioner is: (1) duly licensed and/or certified in compliance with all applicable laws and regulations to provide the care received; and (2) not an **Insured Person** or an **Immediate Family Member**.

B. COSMETIC PLASTIC SURGERY BENEFIT

We will pay the **Reasonable and Customary Expense(s)** incurred if an **Insured Person** requires skin grafting or plastic surgery due to an **Injury** for which Medical Expense Benefits are paid or payable. **We** will not pay more than the Cosmetic Plastic Surgery Maximum Amount shown in the **Schedule** for any one **Injury**.

C. POST TRAUMATIC STRESS DISORDER BENEFIT

We will pay the **Reasonable and Customary Expense(s)** incurred, if, as the result of participation in a specific **Covered Activity** in which a **Traumatic Incident** occurred while coverage under this policy is in force, an **Insured Person** requires medical treatment for a **Post-Traumatic Stress Disorder**. Treatment must be prescribed and monitored by a **Physician**. **We** will not pay more than the Post Traumatic Stress Disorder Maximum Amount shown in the **Schedule** for each **Insured Person** for any one **Covered Activity**.

D. CRITICAL INCIDENT STRESS MANAGEMENT BENEFIT

We will pay the reasonable expenses incurred by a “Critical Incident Stress Management Team” when such services are: (1) requested and authorized by the **Policyholder**; and (2) are required as a result of the **Insured Person's** participation in a specific **Covered Activity** in which a **Traumatic Incident** occurred while coverage under this policy is in force. Covered expenses are those for necessary transportation, meals, and lodging. **We** will not pay more than the Critical Incident Stress Management Maximum Amount which is shown in the **Schedule** regardless of the number of **Insured Persons** treated.

“Critical Incident Stress Management Team (CISMT)” means a formally organized group of mental health professionals and peer support individuals trained to provide support services to emergency service personnel. Such support services include stress debriefing, defusing, demobilization, stress education, spousal support, one-on-one interviews, or on the scene support.

E. FAMILY EXPENSE BENEFIT

If an **Insured Person** requires **Hospital** confinement for three (3) or more consecutive days for an **Injury** or **Illness**, **We** will pay the Family Expense Benefit shown in the **Schedule** for each day of such **Hospital** confinement. This benefit will be payable retroactive to the first day of confinement, after the **Insured**

Person has been confined for three (3) consecutive days.

After such **Hospital** confinement, **We** will also pay 50% of the Family Expense Benefit shown in the **Schedule** for each day an **Insured Person** participates in **Out-Patient Physical Therapy** as a result of such **Injury** or **Illness**.

The Family Expense Benefit will be payable for a combined maximum of 26 weeks for any one **Injury** or **Illness** regardless of whether it is paid at 100% or 50%.

PART VIII. CONTINUATION OF HEALTH INSURANCE PREMIUM BENEFIT

We will pay a benefit equal to the "Continuation of Health Insurance Premium", up to the Continuation Health Insurance Premium Benefit Maximum Amount shown in the **Schedule** if: (1) as a result of **Injury** or **Illness**, an **Insured Person** becomes **Totally Disabled**; (2) **We** have paid six weeks of Total Disability Benefits under the policy; and (3) the **Insured Person** is responsible for his or her "Continuation of Health Insurance Premium". The **Insured Person** must submit to **Us** proof that the premium contribution was previously paid by the **Insured Person's** employer or by the **Insured Person** himself or herself. This coverage does not apply if the **Policyholder** provides health insurance benefits for the **Insured Person**. This benefit also does not apply for an **Insured Person** who is: (1) self employed under item 4 of the **Average Weekly Wage** definition; or (2) an officer or a partner in any organization that purchases health insurance for the **Insured Person**.

"**Continuation of Health Insurance Premium**" means payments by the **Insured Person** to maintain employer-provided individual or family health insurance, after the employer paid premium or contribution becomes the responsibility of the **Insured Person**.

PART IX. TRANSITION BENEFIT

If this Transition Benefit is selected by the **Policyholder** as indicated in the **Schedule**, **We** will pay a weekly Transition Benefit equivalent to the last Total Weekly Disability Benefit if, while the **Insured Person** is receiving Total Disability benefits under the policy, he or she is terminated from his or her regular employment and so remains unemployed after his or her Total Disability benefits end under the policy. **We** will pay this Transition Benefit as long as the **Insured Person** remains unemployed up to a maximum of 26 weeks.

PART X. FELONIOUS ASSAULT BENEFIT

If this Felonious Assault Benefit is selected by the **Policyholder** as indicated in the **Schedule**, **We** will pay a benefit when the **Insured Person** suffers as a result of a "Felonious Assault" that is directed at the **Insured Person** while he or she is participating in a **Covered Activity**, one or more losses for which benefits are payable under the Accidental Death Indemnity Benefit, Accidental Dismemberment Benefit, Cosmetic Disfigurement Resulting from Burns Benefit, Injury Permanent Impairment Benefit, Heart Permanent Impairment Benefit, Illness Permanent Impairment Benefit, or Vision Impairment Benefit provided by the policy.

The amount payable is an additional 50% of the total amount payable under all the benefits specified above. Only one benefit is payable for all losses as a result of the same "Felonious Assault".

This benefit is not applicable if the **Insured Person** is a police officer.

“Felonious Assault” means any willful or unlawful use of force upon the **Insured Person**: (1) with the intent to cause bodily injury to the **Insured Person**; and (2) that results in bodily harm to the **Insured Person**; and (3) that is a felony or a misdemeanor in the jurisdiction in which it occurs.

PART XI. HOME ALTERATION AND VEHICLE MODIFICATION BENEFIT

If an **Insured Person**:

- (1) suffers an **Injury** or **Illness** that is payable under the policy and which results in a permanent and irrevocable loss;
- (2) did not, prior to the date of the **Covered Activity**, require alterations to the home and/or modifications to the vehicle; and
- (3) as a direct result of such **Injury** or **Illness** is now required to make alterations to the home and/or modifications to the vehicle;

We will pay the Home Alteration and Vehicle Modification Benefit for “Home Alteration and Vehicle Modification Expenses” that are incurred within one year after the date of the **Injury** or **Illness**, up to the Home Alteration and Vehicle Modification Maximum Amount shown in the **Schedule**, for all such losses caused by the same **Injury** or **Illness**.

We will pay any “Home Alteration and Vehicle Modification Expenses” incurred by an **Insured Person** in excess of benefits paid or payable under any Workers’ Compensation act or similar law, no fault automobile insurance plan or similar law, and any **Other Valid and Collectible Insurance**.

“Home Alteration and Vehicle Modification Expenses” means one-time expenses that:

- (1) are charged for:
 - (a) alterations to the **Insured Person’s** residence that are necessary to make the residence accessible and habitable for an impaired individual; and
 - (b) modifications to a motor vehicle owned or leased by the **Insured Person** or modifications to a motor vehicle newly purchased for the **Insured Person** that are necessary to make the vehicle accessible to and/or drivable by the **Insured Person**; and
- (2) do not include charges that would not have been made if no insurance existed; and
- (3) do not exceed the usual level of charges for similar alterations and modifications in the locality where the expense is incurred;

but only if the alterations to the **Insured Person’s** residence and the modifications to his or her motor vehicle are:

- (1) made on behalf of the **Insured Person**;
- (2) in compliance with any applicable laws or requirements for approval by the appropriate government authorities; and
- (3) is agreed to and approved by **Us**.

PART XII. OPTIONAL BENEFITS

A. WEEKLY HOSPITAL INDEMNITY BENEFIT

The Weekly Hospital Indemnity Benefit is only provided under the policy if it is selected by the **Policyholder**. If Weekly Income Benefits are payable under the policy, **We** will also pay the Weekly Hospital Indemnity Benefit shown in the **Schedule** if the **Insured Person** eligible to receive the Weekly

Income Benefits requires **Hospital** confinement or **Out-Patient Physical Therapy** for the same **Injury** or **Illness**.

The Weekly Hospital Indemnity Benefit starts on the first day the **Insured Person** is confined to a **Hospital** or begins **Out-Patient Physical Therapy**. If benefits are payable for less than a full week, **We** will pay 1/7 of the Weekly Hospital Indemnity Benefit shown in the **Schedule** for each day the **Insured Person** is confined in the **Hospital** or receives **Out-Patient Physical Therapy**. This benefit will be limited to a maximum of 52 weeks for all **Injuries** or **Illnesses** resulting from the same **Covered Activity**.

If the **Insured Person** is in an intensive, cardiac or critical care unit, the Weekly Hospital Indemnity Benefit Amount shown in the **Schedule** is doubled.

B. ADDITIONAL DISABILITY WEEKLY BENEFIT

The Additional Disability Weekly Benefit is only provided under the policy if it is selected by the **Policyholder**. If an **Insured Person** becomes **Totally Disabled** and is eligible for Total Disability Benefits under the policy, **We** will pay a one time additional weekly benefit equal to the Additional Disability Weekly Benefit shown in the **Schedule** for the first week the **Insured Person** is **Totally Disabled**. If the **Insured Person** is **Totally Disabled** for less than one week, **We** will pay 1/7 of the Additional Disability Weekly Benefit for each full day of **Total Disability**. **We** will pay the Additional Disability Weekly Benefit in addition to any other weekly benefit payable under the policy.

C. EXTENDED TOTAL DISABILITY BENEFIT

The Extended Total Disability Benefit is only provided under the policy if it is selected by the **Policyholder** and the benefit is indicated in the **Schedule**. If the **Insured Person** is **Totally Disabled**, **We** will increase the maximum benefit period as indicated under the Total Disability Benefit from 260 to 520 weeks.

D. 24-HOUR ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT

The 24-Hour Accidental Death and Dismemberment Benefit is only provided under the policy if it is selected by the **Policyholder** and a benefit amount is shown in the **Schedule**. It is payable if a "Covered Person" suffers an **Injury** at any time, whether it be during a **Covered Activity** or not, that results in the "Covered Person's" accidental death or dismemberment such that:

- (1) an Accidental Death Indemnity Benefit or an Accidental Dismemberment Benefit or a Vision Impairment Benefit is payable under the policy; or
- (2) an Accidental Death Indemnity Benefit or an Accidental Dismemberment Benefit or a Vision Impairment Benefit would otherwise be payable under the policy but for the **Injury** not being suffered during a **Covered Activity**.

Any 24-Hour Accidental Death and Dismemberment Benefit payable is in addition to any Accidental Death Indemnity Benefit or an Accidental Dismemberment Benefit or a Vision Impairment Benefit payable under the policy.

"**Covered Person**", as used in this Benefit, means all members who are listed on the **Policyholder's** roster. The roster will be maintained and periodically updated by the **Policyholder**. The roster will be kept on file by the **Policyholder**.

E. OFF-DUTY ACTIVITY ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT

The Off-Duty Activity Accidental Death and Dismemberment Benefit is only provided under the policy if it is selected by the **Policyholder** and a benefit amount is shown in the **Schedule**. It is payable if a "Covered

Person” suffers an **Injury** during an activity that is not a **Covered Activity** that results in the “Covered Person’s” accidental death or dismemberment. In the event of death the benefit amount payable will be equal to the Off-Duty Activity Accidental Death and Dismemberment Benefit indicated in the **Schedule**. In the event of dismemberment or vision loss the benefit amount payable will be calculated from the Off-Duty Activity Accidental Death and Dismemberment Benefit amount indicated in the **Schedule** and the Accidental Dismemberment Chart and the Vision Impairment Chart.

The Off-Duty Activity Accidental Death and Dismemberment Benefit is not available under the policy if the 24-Hour Accidental Death and Dismemberment Benefit is provided under the policy.

“**Covered Person**”, as used in this Benefit, means all members who are listed on the **Policyholder’s** roster. The roster will be maintained and periodically updated by the **Policyholder**. The roster will be kept on file by the **Policyholder**.

EXCLUSIONS

We will not cover any loss caused by or resulting from:

- (1) suicide or any attempt at it, while sane or insane; or intentionally self-inflicted injuries while sane;
- (2) injuries that happen while flying except;
 - (a) as a passenger on a commercial aircraft;
 - (b) as a passenger on any aircraft while taking part in a **Covered Activity**;
- (3) injuries that happen while flying as a crew member, or during parachute jumps from the aircraft;
- (4) war or any act of war, whether declared or undeclared;
- (5) mental or emotional disorders, except as specifically provided for covered **Post Traumatic Stress Disorder**;
- (6) treatment of alcoholism or drug addiction and any complications arising therefrom, except loss caused by **Injury** sustained during and resulting from a **Covered Activity**;
- (7) illness, except as provided by the policy;
- (8) military service of any state or country;
- (9) any activity in football, ice hockey, field hockey, lacrosse, soccer and boxing or
- (10) any league sports event, except as covered under the Organized Team Sports Rider.

OTHER COVERAGE WITH THIS COMPANY

If the **Insured Person** is covered under more than one similar policy issued by **Us**, the total benefits payable will not exceed those payable under the policy which provides the largest benefit.

GENERAL PROVISIONS

Entire Contract; Changes: The policy, the application(s), the summary of coverage(s), and any attached riders, endorsements, amendments, and additional papers make up the entire contract between the **Policyholder** and **Us**.

No change in the policy and the summary of coverage shall be valid until approved by one of **Our** executive officers. Such approval must be noted on or attached to the policy or the summary of coverage. No agent may change or waive any of the provisions of the policy or the summary of coverage.

Statements: In the absence of fraud, all statements made by the **Policyholder** or any **Insured Person** will be considered representations and not warranties. No statement will be used to void the insurance or reduce

benefits unless they appear in a written instrument signed by the **Policyholder** unless a copy of the statement is furnished to the **Insured Person** or his or her beneficiary or personal representative.

Incontestability: The validity of this policy will not be contested after it has been in force for two year(s) from the Policy Effective Date shown in the **Schedule**, except as to nonpayment of premiums.

Grace Period: The policy has a 31 day grace period. This means if the premium is not paid on or before the date it is due, it may be paid during the following 31 days. During the grace period the policy will remain in force.

Notice of Claim: Written notice of claim must be given to **Us** within 30 days after a covered loss occurs, or as soon thereafter as reasonably possible. The notice can be given by or on behalf of the **Insured Person** to **Us** at **Our** Executive Offices or to one of **Our** authorized agents with sufficient information to identify the **Insured Person**, shall be deemed notice to **Us**.

Claim Forms: When **We** receive the written notice of claim, **We** will send the claimant forms for filing proof of loss. If these forms are not furnished within 15 days after receipt of such notice, the claimant will need to meet the proof of loss requirements by giving **Us** written proof of the occurrence, the nature, and the extent of the loss within the time limit stated in the "Proof of Loss" Section. The notice should include the **Insured Person's** name, the **Policyholder's** name, and the **Policy Number**.

Proof of Loss: If the policy provides for periodic payment for a continuing loss, **We** must be given written proof within 90 days after the end of each period for which **We** are liable. For any other loss, **We** must be given written proof within 90 days after that loss. If it was not reasonably possible to give written proof in the time required, **We** will not reduce or deny the claim for this reason, if the proof is filed as soon as reasonably possible. However, proof must be given as soon as reasonably possible.

Time of Payment of Claims: When **We** receive written proof of loss, **We** will pay any benefits due. Benefits that provide for periodic payment will be paid at least monthly. When **Our** liability ends, **We** will pay any remaining balance as soon as **We** receive written proof of loss.

Payment of Claims: Any Loss of Life Benefit will be paid in accordance with the beneficiary designation on record with **Us** or the **Policyholder**.

If no beneficiary is named, Loss of Life Benefits will be paid to the first surviving class of the following classes: the **Insured Person's** (1) spouse; (2) child(ren); (3) parents; or (4) brothers or sisters. Otherwise, **We** will pay benefits to the **Insured Person's** estate.

All other benefits are payable to the **Insured Person**, unless otherwise indicated in the policy. **We** may pay all or a part of any benefits for health care services directly to the provider. **We** cannot require that the service be given by a certain provider.

If the **Policyholder** requests, **We** may (at **Our** option) pay benefits to the **Policyholder**. The **Policyholder** will then pay the **Insured Person** or beneficiary entitled to receive the benefits.

Any payment **We** make in good faith will end **Our** liability to the extent of the payment.

Physical Examination and Autopsy: **We**, at **Our** expense, have the right to have the **Insured Person** examined as often as reasonably necessary while a claim is pending under the policy. **We** may also have an autopsy performed unless prohibited by law.

Legal Actions: No legal action may be brought to recover on the policy within 60 days after written proof of loss has been given as required by the policy. No such action may be brought after three years from the time

written proof of loss is required to be given.

Change of Beneficiary: The **Insured Person** can change the beneficiary at any time by sending a written notice to the **Policyholder** or **Us**. The beneficiary's consent is not required for this or any other change in the policy, unless the designation of the beneficiary is irrevocable.

Conformity with State Statutes: Any provision of the policy, which, on its effective date, is in conflict with the laws of the state in which the **Insured Person** resides on that date, is amended to conform to the minimum requirements of such laws.

Clerical Error: The insurance of any **Insured Person** will not be affected by a clerical error made by the **Policyholder** or **Us**. An error will not continue the insurance of an **Insured Person** beyond the date it would end under the policy terms if the error had not been made.

Examination and Audit: **We** shall be permitted to examine and audit a **Policyholder's** records relating to the policy at: (1) any reasonable time during the policy term; and (2) within two years after the expiration of the policy or until all claims have been settled or adjusted, whichever is later.

New Entrants: New eligible persons added from time to time to the group of **Insured Persons** originally insured under this plan will be automatically covered under the policy.

Duty to Cooperate: The **Policyholder** will cooperate with **Us** and assist **Us**, as **We** request, in the investigation of any claim reported under the policy. The **Policyholder** will not voluntarily make payments, assume obligations, or incur expenses, except at the cost of the **Policyholder**.

Not In Lieu Of Workers' Compensation: The policy is not a Workers' Compensation policy. It does not provide Workers' Compensation Benefits.

Noncompliance with Policy Requirements: Any express waiver by **Us** of any requirements of the policy will not constitute a continuing waiver of such requirements. Any failure by **Us** to insist upon compliance with any policy provision will not operate as a waiver or amendment of that provision.

Misstatement of Age: If the benefits for which the **Insured Person** is insured are based on age and the **Insured Person** has misstated his or her age, there will be an adjustment of said benefit based on his or her true age. **We** may require satisfactory proof of age before paying any claim.

Assignment: The policy is non-assignable. An **Insured Person** may not assign any of his or her rights, privileges or benefits under the policy.



AIG Domestic Accident & Health Division

A Division of the AIG Companies®

NATIONAL UNION FIRE INSURANCE COMPANY OF PITTSBURGH, PA.

Executive Offices: 70 Pine Street, New York, NY 10270

(212) 770-7000

(a capital stock company, herein referred to as the Company)

This summary of coverage furnished by National Union Fire Insurance Company describes the coverage that will be provided for all those persons called **Insured Persons** as defined in this summary of coverage. Coverage will be provided for losses described herein subject to the terms of the Master Policy (called "the policy" in this summary of coverage). This summary of coverage is issued to the **Policyholder** named in the **Schedule**.

The coverage provided under this summary of coverage is valid only when the required premium due as shown in the **Schedule** has been paid. The complete terms and conditions governing each **Insured Person's** coverage are in the policy issued to the **Policyholder** named in the **Schedule**. The policy may be changed or terminated without consent of or notice to each **Insured Person**.

CONSIDERATION – TERM

Coverage under the policy is provided in consideration of the payment of the premium by the **Policyholder**. The premium due is shown in the **Schedule**. The term of coverage for such **Policyholder** will begin on the Policy Effective Date and end on the Policy Termination Date as shown in the **Schedule**. All periods of insurance will begin and end at 12:01 AM Standard Time at the address of the **Policyholder**.

RENEWAL

Coverage may be renewed by **Us** for further consecutive terms by the payment of **Our** premium rate in effect at the time of renewal. If this coverage is not renewed, insurance will stop on the date to which premiums have been paid subject to the Grace Period provisions.

INDIVIDUAL EFFECTIVE AND TERMINATION DATES

Coverage for an **Insured Person** will take effect on the later of: (1) the Policy Effective Date shown in the **Schedule**; or (2) the date he or she becomes an **Insured Person** as defined in this summary of coverage.

Coverage for an **Insured Person** will end on the earliest of: (1) the date the policy terminates; (2) the date he or she is no longer an **Insured Person** as defined in this summary of coverage; or (3) the date the **Policyholder's** coverage ends.

Termination of coverage will not affect any loss resulting from participation in a **Covered Activity** when such participation occurred prior to the date of termination.

The President and Secretary of National Union Fire Insurance Company of Pittsburgh, Pa. witness this summary of coverage:

President

Secretary

PLEASE READ THIS SUMMARY OF COVERAGE CAREFULLY.

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SCHEDULE OF COVERAGES

Policyholder:

Policy Number VFP:

Participating Organization:
(Name and Address)

Policy Effective Date:

Term:

Policy Termination Date:

Premium: \$

This summary of coverage provides only those following benefits that have a specified amount entered opposite the name of the benefit. Benefits that are followed by entry of the word "none" are not provided.

PART COVERAGE

AMOUNT OF INSURANCE

I. Loss of Life Benefits

A. Accidental Death Benefits

(1) Accidental Death Indemnity Benefit [\$]

(2) Seat Belt Benefit Amount [\$]

B. Illness Loss of Life Benefit [\$]

C. Dependent Child Benefit Amount [\$10,000]

D. Spousal Support Benefit Amount [\$5,000]

E. Memorial Benefit Amount [\$2,000]

II. Lump Sum Living Benefits

A. Accidental Dismemberment Principal Sum [\$]

B. Vision Impairment Benefit [\$]

C. Injury Permanent Impairment Benefit Principal Sum [\$]

D. Heart Permanent Impairment Benefit Principal Sum [\$]

E. Illness Permanent Impairment Benefit Principal Sum [\$]

F. Cosmetic Disfigurement Resulting From Burns Principal Sum [\$]

G. HIV Positive Lump Sum Benefit [\$]

III. Weekly Income Benefits

A. Total Disability Benefits

(1) Total Disability Weekly Income Benefit (first 28 days) [\$]

(2) Total Disability Maximum Weekly Amount (after 28 days) [\$]

(3) Total Disability Minimum Weekly Amount [\$]

B. Partial Disability Benefits

(1) Partial Disability Weekly Income Benefit (first 28 days) [50%/\$]

(2) Partial Disability Maximum Weekly Amount (after 28 days) [50%/\$]

(3) Partial Disability Minimum Weekly Amount [50%/\$]

IV. Occupational Retraining Benefit Maximum Amount [\$20,000]

V. Medical Expense Benefits

A. Medical Expense Maximum Amount [\$]

Medical Expense Benefit Options

(1) Excess of Workers' Compensation or No-Fault Auto Insurance Benefits ☐

(2) Excess of Workers' Compensation, No-Fault Auto Insurance and Other Group Insurance ☐

(3) Primary Medical Expense Benefit ☐

- B. Cosmetic Plastic Surgery Maximum Amount.....[\$10,000]
- C. Post Traumatic Stress Disorder Maximum Amount.....[\$10,000]
- D. Critical Incident Stress Management Maximum Amount (Per Covered Activity).....[\$2,500]
- E. Family Expense Benefit[\$]

VI. **Felonious Assault Benefit**..... ☐ Yes ☐ No

VII. **Home Alteration and Vehicle Modification Benefit Maximum Amount**.....[\$15,000]

VIII. **Optional Benefits**

- A. Weekly Hospital Indemnity Benefit[\$]
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- C. 24-Hour Accidental Death and Dismemberment Benefit.....[\$]
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POLICY FORMS ATTACHED AT ISSUANCE:

| | |
|-------------------------|---|
| [V40007NUFIC(Rev 01/09) | Career Personnel Rider |
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| V40012NUFIC | Optional Subrogation Rider |
| V40013NUFIC | Payment of Claims Rider |
| V40014NUFIC | Domestic Partner Endorsement |
| V40015NUFIC | Civil Unions Partner Endorsement |
| V40020NUFIC | Continuation of Health Insurance Premium Benefit Rider (Career Members) |
| 89644 (7/05) | Coverage Territory Endorsement (OFAC) |
| V40006NUFIC | Amendatory Endorsement # [X] |

[**ADDITIONAL ENTITIES:**

[ABC Fire Company]

DEFINITIONS

(Additional defined terms can be found throughout this summary of coverage)

Any capitalized terms in the policy, application, this summary of coverage, and any riders, endorsements, amendments or other attached papers are to be given the meanings as ascribed in this section or as later defined.

Average Weekly Wage – means an average weekly wage determined by the greater of: (1) the total of wages, salaries, tips, or unemployment compensation for the calendar year immediately preceding the year in which the loss occurred; (2) the average weekly wage earned in the 12 months preceding the loss; (3) the annualized weekly wage earned in the three months preceding the loss; or (4) for the self-employed, the amount taken from Schedule C, E, or F which is reported on IRS Form 1040 as net taxable income, excluding rental, investment or passive income. The **Average Weekly Wage** will be verified by the **Insured Person's** employer and/or tax records.

Consumer Price Index – means the consumer price index published by the U.S. Department of Labor's Bureau of Labor Statistics for All Urban Consumers, All Items (CPI-U).

Covered Activity – means any activity, including travel directly to and from such activity, which is a normal duty of an **Insured Person**, including any: (1) emergency response for fire suppression and rescue or emergency medical activity; (2) training exercise which simulates an emergency and where active physical participation is required; (3) **Firematic Events or Contests**; (4) class room training; (5) fund-raising activities including athletic activities solely for the purpose of raising funds for the **Policyholder** or other non-profit organization when such fund-raising is performed as an activity of the **Policyholder**, except any activity in football, ice or field hockey, lacrosse, soccer or boxing; (6) official functions attended primarily by members of the **Policyholder** for which the purpose is to further the business of the **Policyholder** (i.e. installation dinners, banquets, etc.); (7) official conventions, conferences or meetings of emergency fire, rescue or medical personnel attended by the **Insured Person** on behalf of the **Policyholder** including personal travel or activities undertaken attendant to such convention, conference or meeting; and (8) participation in pre-approved covered athletic events or programs conducted on the premises of the **Policyholder**. Under no circumstances is there coverage for participation in the athletic events listed in Exclusion number 9.

The **Covered Activity** must be performed at the direction, or with the knowledge, of an officer of the **Policyholder**, unless immediate action is required of the **Insured Person** at the scene of an emergency not on behalf of the **Policyholder** or any other organization.

Firematic Events or Contests – means practice or participation in an organized event intended to enhance the **Insured Person's** skills or emergency reaction times. These events include, but are not limited to, departmental or interdepartmental: (1) apparatus pumping contests; (2) battle of the barrel; (3) antique pumping; (4) hose rolling contests; (5) equipment donning contests; (6) bucket brigades; (7) ladder climbs; (8) tug of war contests; and (9) apparatus operation rodeos.

Gainful Occupation – means an occupation for which an **Insured Person** is qualified by reason of education, training or experience, which has a reasonable expectation to provide more than 85% of pre-disability earnings.

Hospital - means a facility which: (1) is operated according to law for the care and treatment of injured and sick people; (2) has organized facilities for diagnosis and surgery on its premises or in facilities available to it on a prearranged basis; (3) has 24 hour nursing service by registered nurses (R.N.'s); and (4) is supervised by one or more **Physicians**. A Hospital does not include: (1) a nursing, convalescent or geriatric unit of a hospital when a patient is confined mainly to receive nursing care; or (2) a facility which is, other than incidentally, a rest home, nursing home, convalescent home or home for the aged; nor does it include any ward, room, wing, or other section of the hospital that is used for such purposes.

Illness – means any disease, sickness, or infection of an **Insured Person** while coverage under the policy is in force as to the **Insured Person**. The **Illness** must: (1) manifest itself during a specific **Covered Activity** with the result that the **Insured Person** interrupts his or her participation in such **Covered Activity** in order to receive immediate medical treatment; or (2) directly result from participation in a **Covered Activity** and also result in the **Insured Person** receiving medical treatment within 48 hours of participation in such **Covered Activity**. The requirement that medical treatment be received within 48 hours is waived for **Infectious Diseases**. Medical treatment means treatment by a **Physician** or at a **Hospital** for the **Illness**.

Immediate Family Member – means the **Insured Person's** spouse, child, parent, brother or sister.

Infectious Disease – means a disease included within the list of potentially life-threatening infectious diseases, developed by the Secretary of Health and Human Services, pursuant to Title XXVI of the Public Health Service Act, such as hepatitis, clostridium, rubella and tuberculosis.

Injury(ies) – means accidental bodily injury sustained by the **Insured Person**: (1) during and resulting from an **Insured Person's** participation in a specific **Covered Activity** while coverage under the policy is in force as to the **Insured Person**; (2) which directly (independent of sickness, disease, mental incapacity or any other cause) causes a loss to the **Insured Person**; and (3) which is not otherwise defined as an **Illness**. The term **Injury**, for the purposes of this policy, shall not include human immunodeficiency virus (HIV), acquired immune deficiency syndrome (AIDS) or AIDS related complex (ARC), or any heart or circulatory malfunction.

Insured Person – means: (1) a paid employee is one who looks to the **Policyholder** for his or her primary means of living while acting within the scope of his or her employment and while covered under policy; and (2) any bystander deputized at the time of the emergency by an official of the **Policyholder** to assist in an emergency, but only during the actual emergency. An employee will be deemed to look to the **Policyholder** for his or her primary source of income if he or she: (1) averages [25] hours or more employment per week; or (2) is salaried and works a schedule of more than [25] hours per week. The time frame used to determine the average hours or the salaried schedule will be the same time frame used to calculate the **Average Weekly Wage**.

Other Valid and Collectible Insurance – means any: (1) group plan, program, or insurance policy; (2) any other group hospital, surgical or medical benefit plan; (3) union welfare plans or group employer or employee benefit programs; or (4) any no-fault automobile insurance plan or similar law. **Other Valid and Collectible Insurance** will not include benefits provided by the United States Social Security Act or any individual disability insurance plans.

Out-Patient Physical Therapy – means rehabilitative physical therapy which is: (1) received without being confined overnight in a **Hospital** as a registered bed patient; (2) an approved therapy program; (3) necessary for the rehabilitation of an **Insured Person** from an **Injury** or an **Illness** for which he or she was confined in a **Hospital** for treatment; (4) administered by a licensed physical therapist; and (5) monitored by a **Physician**.

Partial Disability, Partially Disabled – means, for an **Insured Person** with an occupation producing wages as described in the definition of **Average Weekly Wage**, the inability to perform one or more, but not all, of the material and substantial duties of his or her own occupation. If the **Insured Person** does not have an occupation producing wages as described in the definition of **Average Weekly Wage**, **Partial Disability, Partially Disabled** means: (1) the inability to perform one or more, but not all, of the material and substantial duties of an occupation for which the **Insured Person** is qualified by reason of education, training, or experience; or (2) the inability to perform one or more, but not all, of the regular activities of the **Insured Person**. The **Insured Person** must be under the regular care of a **Physician** during **Partial Disability**.

Permanent Impairment - means a medical condition which is a physical or functional abnormality or loss, which remains after the maximum medical rehabilitation has been achieved, and which is considered stable or

non-progressive by the **Physician** at the time an evaluation is made.

Physician – means any duly licensed medical practitioner: (1) who is acting within the scope of his or her license; and (2) who is not the **Insured Person** or an **Immediate Family Member**.

Policyholder – means a non-profit emergency service organization or municipality or political subdivision that elects coverage under the policy and pays the required premium. The **Policyholder** is named in the **Schedule**. Coverage for such **Policyholder** will be in force at 12:01 A.M. on the Policy Effective Date shown in the **Schedule** subject to payment of the required premium. Coverage is limited to **Insured Persons** of any fire, emergency, rescue or ambulance department of the municipality or political subdivision.

Post Traumatic Stress Disorder – means emotional stress resulting from a **Traumatic Incident** experienced by an **Insured Person** which adversely affects the psychological and physical well-being of the **Insured Person**.

Reasonable and Customary Expense – means an expense which: (1) is charged for treatment, supplies or medical services medically necessary to treat the **Insured Person's** condition; (2) does not exceed the usual level of charges for similar treatment, supplies or medical services in the locality where the expense is incurred; and (3) does not include charges that would not have been made if no insurance existed.

Schedule – means the Schedule of Coverages which is a part of this summary of coverage.

Total Disability, Totally Disabled – means, for an **Insured Person** with an occupation producing wages as described in the definition of **Average Weekly Wage**, the inability to perform all of the material and substantial duties of his or her own occupation. If the **Insured Person** does not have an occupation producing wages as described in the definition of **Average Weekly Wage**, **Total Disability, Totally Disabled** means: (1) the inability to perform all of the material and substantial duties of an occupation for which the **Insured Person** is qualified by reason of education, training, or experience; or (2) the inability to perform all of the regular activities of the **Insured Person**. The **Insured Person** must be under the regular care of a **Physician** during **Total Disability**.

Traumatic Incident – means an abnormal experience, outside the range of usual human experiences and includes, but is not limited to: (1) line-of-duty death or serious injury to other **Insured Person's**; (2) a single incident having multiple casualties; (3) death or serious injury of a child; and (4) dealing with victims known to the **Insured Person**.

We, Us, or Our refers to National Union Fire Insurance Company of Pittsburgh, Pa. **Our** Executive Offices are located at 70 Pine Street, New York, New York 10270.

PART I. LOSS OF LIFE BENEFITS

A. ACCIDENTAL DEATH BENEFITS

- (1) Accidental Death Indemnity Benefit. **We** will pay the Accidental Death Indemnity Benefit shown in the **Schedule** if **Injury** to an **Insured Person** results in the **Insured Person's** death.
- (2) Seat Belt Benefit. If an Accidental Death Indemnity Benefit is payable hereunder and the accident which caused the **Insured Person's** accidental death occurred while the **Insured Person** was wearing a properly fastened automotive seat belt, **We** will pay an additional amount equal to the Seat Belt Benefit Amount shown in the **Schedule**. This Seat Belt Benefit is not payable for **Injuries** sustained by an **Insured Person** while standing inside or on the tailboard of any vehicle.

B. ILLNESS LOSS OF LIFE BENEFIT

We will pay the Illness Loss of Life Benefit shown in the **Schedule** if death to an **Insured Person**: (1) occurs during a specific **Covered Activity** and is not otherwise payable as an Accidental Death Indemnity Benefit; or (2) occurs due to an **Illness** covered as a result of participation in a specific **Covered Activity**. Either: (1) death; or (2) medical treatment for the **Illness** must occur within 48 hours of the **Covered Activity**. The requirement that death occurs or medical treatment for the **Illness** be received within 48 hours is waived for **Infectious Disease**. Medical treatment means treatment by a **Physician** or at a **Hospital** for the **Illness**.

No Illness Loss of Life Benefit will be payable if an Accidental Death Indemnity Benefit is payable under the policy, or if, as a direct result of participation in the same **Covered Activity**, an HIV Positive Benefit was paid to the **Insured Person** under the policy.

C. DEPENDENT CHILD BENEFIT

We will pay the Dependent Child Benefit Amount shown in the **Schedule** for each "Dependent Child" if either an Accidental Death Indemnity Benefit or an Illness Loss of Life Benefit is payable under the policy. **We** may make payment directly to the "Dependent Child's": (1) guardian; or (2) to an individual or institution with custody of the "Dependent Child" if; (a) the "Dependent Child" is a minor or is not competent to give a valid receipt for payment due him or her; and (b) no request for payment has been received by **Us** from a duly appointed guardian or other legally appointed representative. Payment made in this manner will release **Us** from all liability to the extent of any payment made.

"**Dependent Child**" means any unmarried child of the **Insured Person** who was dependent upon the **Insured Person** and either claimed on the **Insured Person's** final tax return, or was dependent as a result of a legally enforceable agreement filed with a court or other administrative body.

D. SPOUSAL SUPPORT BENEFIT

We will pay the Spousal Support Benefit Amount shown in the **Schedule** to the **Insured Person's** surviving spouse if either an Accidental Death Indemnity Benefit or an Illness Loss of Life Benefit is payable under the policy.

E. MEMORIAL BENEFIT

We will pay the Memorial Benefit Amount shown in the **Schedule** to the **Policyholder**, to be used to cover final expenses incurred by the **Policyholder** on behalf of the **Insured Person**, if either an Accidental Death Indemnity Benefit or an Illness Loss of Life Benefit is payable under the policy.

PART II. LUMP SUM LIVING BENEFITS

A. ACCIDENTAL DISMEMBERMENT BENEFIT

If **Injury** to an **Insured Person** shall result in a "Loss" listed below, **We** will pay the indicated percentage of the Accidental Dismemberment Principal Sum shown in the **Schedule** for the "Loss" suffered. If the **Insured Person** suffers more than one "Loss" as a result of any one accident, only one amount, the largest, will be paid.

Accidental Dismemberment Chart

| <u>For Loss of:</u> | <u>% of Accidental Dismemberment Principal Sum Payable</u> |
|--|--|
| Both Hands or Both Feet | 100 |
| One Hand and One Foot..... | 100 |
| Entire Sight of Both Eyes | 100 |
| One Hand and Entire Sight of One Eye | 100 |
| One Foot and Entire Sight of One Eye..... | 100 |
| Speech and Hearing | 100 |
| One Arm or One Leg..... | 75 |
| Speech or Hearing | 50 |
| One Hand or One Foot..... | 50 |
| Entire Sight of One Eye..... | 50 |
| Both Thumbs | 10 |
| One Thumb | 5 |
| Each Joint of a Finger or Toe..... | 1 |

“Loss” means, with reference to the foot, a complete severance through or above the ankle joint; with reference to the hand, the complete severance of the distal, proximal or medial phalanx of four fingers; with reference to the arm or leg, the complete severance through or above the elbow or knee joint; with reference to the thumb, the complete severance at the metacarpophalangeal joint; and with reference to a joint of a finger or toe, the complete severance of a distal, proximal or (where applicable) medial phalanx. **“Loss”** of speech or hearing means the total and irrecoverable loss of speech and/or hearing. **“Loss”** of sight means the total and irrecoverable loss of sight.

B. VISION IMPAIRMENT BENEFIT

If **Injury** to an **Insured Person** shall result in “Permanent Damage” to the **Insured Person’s** eyesight, **We** will pay the indicated percentage of the Vision Impairment Benefit shown in the **Schedule**, for each impaired eye, based on the degree of vision impairment according to the Vision Impairment Chart shown below. This chart shall apply separately to each eye.

Vision Impairment Chart

| <u>Vision Impairment</u> | <u>% of Vision Impairment Benefit Payable Per Each Eye</u> |
|--------------------------|--|
| 20/20 | 0.00% |
| 20/30 | 2.75% |
| 20/40 | 5.50% |
| 20/50 | 8.25% |
| 20/60 | 11.00% |
| 20/80 | 16.50% |
| 20/100 | 22.00% |
| 20/120 | 28.00% |
| 20/150 | 36.00% |
| 20/180 | 44.50% |
| 20/200 or poorer | 50.00% |

If the sight of an eye is less than 20/20 before the “Permanent Damage”, **We** will pay a benefit based only upon the additional impairment due to the **Injury**. In no event will **We** pay both Accidental Dismemberment Benefits for a loss of sight and Vision Impairment Benefit for **Injury** to the same eye sustained while participating in the same **Covered Activity**.

Any Vision Impairment Benefit paid or payable hereunder will be in addition to any Accidental Dismemberment Benefit paid or payable under the policy. However, in no event will the total amount of benefits payable as a result of any one accident exceed 100% of the largest Principal Sum shown in the **Schedule** for these Benefits.

“**Permanent Damage**” means, with reference to the eyes, irreparable **Injury** which results in permanently impaired vision, but not in total and irrecoverable loss of sight.

C. INJURY PERMANENT IMPAIRMENT BENEFIT

We will pay the Injury Permanent Impairment Benefit shown in the **Schedule** if an **Insured Person** suffers a **Permanent Impairment** due to an **Injury** and the **Insured Person** participates in an approved physical rehabilitation program if his or her physical condition so warrants. In no event will an Injury Permanent Impairment Benefit be payable if the Heart Permanent Impairment Benefit or an Illness Permanent Impairment Benefit is paid or payable for any one **Injury** or **Illness** sustained while participating in the same **Covered Activity**.

To Determine the Benefit Payable

The **Insured Person's Permanent Impairment**, due to an **Injury**, will be assigned an impairment value by an examining **Physician**. This value will be expressed as a percentage in relation to the whole person. The impairment value will be determined by the most current edition of the American Medical Association's (AMA) “Guides to the Evaluation of Permanent Impairment”. This percentage value will be applied to the Injury Permanent Impairment Benefit Principal Sum shown in the **Schedule** to determine the Injury Permanent Impairment Benefit payable under the policy.

If, due to an **Injury**, the **Insured Person** has a **Permanent Impairment** rating of 90% or higher then the **Insured Person** will receive 125% of the Injury Permanent Impairment Benefit Principal Sum.

For example:

- (1) if a knee **Injury** resulted in an AMA guideline lower extremity impairment rating of 38%, which equates to 15% of the whole body, the benefit would be 15% of the Injury Permanent Impairment Benefit; or
- (2) if a combination of leg and back **Injuries** result in an AMA guideline whole person impairment rating of 12% and 17%, respectively, which equates to a combined whole person impairment rating of 27%, the benefit would be 27% of the Injury Permanent Impairment Benefit; or
- (3) if a fracture at the second cervical vertebra results in incomplete quadriplegia with an AMA guideline whole person impairment rating of 93%, the benefit would be increased to 125% of the Injury Permanent Impairment Benefit since the impairment rating is 90% or higher.

Any Injury Permanent Impairment Benefit paid or payable hereunder will be in addition to any Accidental Dismemberment Benefit or Vision Impairment Benefit paid or payable under the policy. However, in no event will the total amount of benefits payable as a result of any one accident exceed 100% of the largest Principal Sum shown in the **Schedule** for these benefits, unless the **Permanent Impairment** rating for an **Injury** is 90% or higher in which case 125% of the Principal Sum is payable.

If the **Insured Person** has an impairment prior to the time of **Injury**, the impairment value that represents the pre-existing condition will be deducted from the **Permanent Impairment** evaluation due to the **Injury** as described above.

D. HEART PERMANENT IMPAIRMENT BENEFIT

We will pay a Heart Permanent Impairment Benefit shown in the **Schedule** if the **Insured Person** has a "Heart Permanent Impairment" due to a heart condition that results in at least 26 weeks of **Total Disability**, based upon the degree of heart impairment according to the Heart Permanent Impairment Benefit Chart shown below. The Heart Permanent Impairment Chart shows the percentage of the Heart Permanent Impairment Benefit due.

To Determine the Benefit Payable

No more than nine months after the **Covered Activity**, the **Insured Person's** highest "Left Ventricular Ejection Fraction" and lowest "New York Heart Association Functional Classification" will be obtained and compared to the Heart Permanent Impairment Benefit Principal Sum shown in the **Schedule**. The ratings must result from evaluations performed after the **Covered Activity** date.

If the **Insured Person** had a "Left Ventricular Ejection Fraction" of 35% or lower prior to the **Covered Activity** date, no Heart Permanent Impairment Benefit is due.

Heart Permanent Impairment Benefit Chart

| Left Ventricular Ejection Fraction | New York Heart Association Functional Classification | Heart Permanent Impairment Benefit Due |
|------------------------------------|--|--|
| 26 to 30% function | Class II | 25% |
| 26 to 30% function | Class III or IV | 50% |
| 21 to 25% function | Class II or III | 50% |
| 21 to 25% function | Class IV | 75% |
| Less than 21% function | Class II or III | 75% |
| Less than 21% function | Class IV | 100% |

The benefit due is calculated by multiplying the percentage due and the Principal Sum. The benefit is further modified by the **Insured Person's** age on the date of the heart impairment, according to the following table:

- | | |
|------------------|------------------------------|
| • Age 40 or less | – 125% of the amount payable |
| • Age 41 to 65 | – 75% of the amount payable |
| • Age 66 or over | – 50% of the amount payable |

For example:

- (1) if a 30 year old (on the date of heart impairment) has a "Left Ventricular Ejection Fraction" of 17% and a "New York Heart Association Functional Classification" of Class IV, the benefit would be 100% of the Heart Permanent Impairment Benefit times 125% since the age is less than 40, for a total benefit of 125% of the Heart Permanent Impairment Benefit; or,
- (2) if a 55 year old (on the date of heart impairment) has a "Left Ventricular Ejection Fraction" of 19% and a "New York Heart Association Functional Classification" of Class IV, the benefit would be 100% of the Heart Permanent Impairment Benefit times 75% since the age is between 41 and 65, for a total benefit of 75% of the Heart Permanent Impairment Benefit; or,
- (3) if a 68 year old (on the date of heart impairment) has a "Left Ventricular Ejection Fraction" of 18% and a "New York Heart Association Functional" Classification of Class IV, the benefit would be 100% of the Heart Permanent Impairment Benefit times 50% since the age is 66 or over, for a total benefit of 50% of the Heart Permanent Impairment Benefit.

“Heart Permanent Impairment” means a medical condition which is a physical and functional abnormality or loss as a consequence of an **Insured Person** sustaining a heart impairment as a result of a **Covered Activity**, resulting in: (1) a “Left Ventricular Ejection Fraction” of 30% or less; and (2) a “New York Heart Association Functional Classification” of II, III, or IV; and (3) at least 26 weeks of **Total Disability**.

“Left Ventricular Ejection Fraction” means a clinically used measure of the percentage of blood the heart is able to eject from the left ventricle.

“New York Heart Association Functional Classification” is a standard measurement of how heart function affects activities of daily living. Below is a summary of the New York Heart Association Classification:

- I No symptoms and no limitation in ordinary physical activity.
- II Mild symptoms and slight limitation during ordinary activity. Comfortable at rest.
- III Marked limitation in activity due to symptoms, even during less-than-ordinary activity. Comfortable only at rest.
- IV Severe limitations. Experiences symptoms even while at rest.

E. ILLNESS PERMANENT IMPAIRMENT BENEFIT

We will pay the Illness Permanent Impairment Benefit shown in the **Schedule** if **Illness** to an **Insured Person** results in five years (260 weeks) of Total Disability Benefits.

To Determine the Benefit Payable

If the **Insured Person** is unable to return to his or her occupation after five years (260 weeks) of Total Disability Benefits, 50% of the Illness Permanent Impairment Benefit shown in the **Schedule** is payable. If the **Insured Person** is unable to return to any **Gainful Occupation** after five years (260 weeks) of Total Disability Benefits, 75% of the Illness Permanent Impairment Benefit shown in the **Schedule** is payable. If the **Insured Person** has been approved for Social Security disability benefits or, if not eligible for Social Security disability benefits, otherwise meets the eligibility criteria for Social Security disability benefits, 125% of the Illness Permanent Impairment Benefit as shown in the **Schedule** is payable.

The five year (260 week) period of **Total Disability** does not need to be consecutive weeks but must be payable as a result of one **Illness** sustained while participating in the same **Covered Activity**.

If an **Insured Person** has received a Heart Permanent Impairment Benefit and later becomes eligible for payment under this benefit for the same condition, the amount payable under this benefit is the Illness Permanent Impairment Amount shown in the **Schedule**, less the amount previously paid under the Heart Permanent Impairment Benefit. The percentage schedule as described in the first paragraph of this section will also apply to the total amount payable.

F. COSMETIC DISFIGUREMENT RESULTING FROM BURNS BENEFIT

We will pay the benefits under this provision if, as the result of **Injury**, an **Insured Person** suffers from a cosmetic disfigurement due to a burn that is classified as a full thickness or third degree burn.

To Determine the Benefit Payable

Any Cosmetic Disfigurement Resulting From Burns Benefit paid or payable under this benefit will be based on a percentage of the Cosmetic Disfigurement Resulting From Burns Principal Sum shown in the **Schedule** and depend on the area of the body which was burned. The benefit payable for any one loss is determined by the following formula:

- (1) First the area of the body that was burned is assigned an area classification factor by using the chart shown below. Each body part is assigned a classification relative to its visual exposure (i.e., the higher the classification, the more visual the exposure);
- (2) This area classification factor is multiplied by the percentage of body surface actually burned. The attending **Physician** will determine the percentage applicable to each burn. The chart below lists the maximum allowance percentage for body surface burned for each area classification;
- (3) Steps 1 and 2 will produce a numerical factor that will be multiplied by the Cosmetic Disfigurement Resulting From Burns Principal Sum to determine the percentage of the Cosmetic Disfigurement Resulting From Burns Principal Sum payable under this benefit. For example, by using the Cosmetic Burn Chart shown below:
 - (a) if the entire surface of the right hand and forearm were burned the benefit would be $5 \times 4.5\% = 22.5\%$ of the Cosmetic Disfigurement Resulting From Burns Principal Sum payable; or
 - (b) if 50% of the surface of the right hand and forearm were burned the benefit would be $5 \times 2.25\%$ (which is 50% of 4.5) = 11.25% of the Cosmetic Disfigurement Resulting From Burns Principal Sum payable.

The following is a burn chart from which benefits can be determined. This chart only represents the maximum percentage of the Cosmetic Disfigurement Resulting From Burns Principal Sum payable for any one covered loss. If the **Insured Person** suffers burns in more than one area as a result of any one accident, benefits will not exceed more than 100% of the Cosmetic Disfigurement Resulting From Burns Principal Sum.

Cosmetic Burn Chart

| Body Part | Area Classification | Maximum Allowable % for Area Surface Burned | Maximum % of Cosmetic Disfigurement Resulting from Burns Principal Sum |
|--------------------------------|----------------------------|--|---|
| Face, Neck, Head | 11 | 9.0% | 99.0% |
| Hand & Forearm (Right) | 5 | 4.5% | 22.5% |
| Hand & Forearm (Left) | 5 | 4.5% | 22.5% |
| Upper Arm (Right) | 3 | 4.5% | 13.5% |
| Upper Arm (Left) | 3 | 4.5% | 13.5% |
| Torso (Front) | 2 | 18.0% | 36.0% |
| Torso (Back) | 2 | 18.0% | 36.0% |
| Thigh (Right) | 1 | 9.0% | 9.0% |
| Thigh (Left) | 1 | 9.0% | 9.0% |
| Lower Leg (Right) (below knee) | 3 | 9.0% | 27.0% |
| Lower Leg (Left) (below knee) | 3 | 9.0% | 27.0% |

The percentage shown is based on 100% of the Body Part identified being burned. Please refer to the **Schedule** for the amount of the Cosmetic Disfigurement Resulting From Burns Principal Sum.

Any Cosmetic Disfigurement Resulting From Burns Benefit paid or payable hereunder will be in addition to any Accidental Dismemberment Benefit, Injury Permanent Impairment Benefit, Illness Permanent Impairment Benefit, or Heart Permanent Impairment Benefit paid or payable under the policy. However, in no event will the total amount of benefits payable as a result of any one accident exceed 100% of the largest Principal Sum shown in the **Schedule** for these benefits.

G. HIV POSITIVE LUMP SUM LIVING BENEFIT

We will pay the HIV Positive Lump Sum Living Benefit shown in the **Schedule** if, as a direct result of

participation in a specific **Covered Activity**, an **Insured Person** tests "HIV Positive".

In the event that an HIV Positive Lump Sum Living Benefit and (1) an Illness Loss of Life Benefit or (2) an Illness Permanent Impairment Benefit are both payable under the policy as a result of any one **Illness** sustained while participating in the same **Covered Activity**, only one benefit, the largest, will be paid.

"**HIV**" means human immunodeficiency virus.

"**HIV Positive**" means the presence of **HIV** antibodies in the blood of an **Insured Person** as substantiated through both a positive screening test (enzyme-linked immunosorbent assay, ELISA) and a positive supplemental test such as Western Blot. All such tests must be approved by the Food and Drug Administration (FDA) with the interpretation of positivity as specified by the manufacturer(s).

PART III. WEEKLY INCOME BENEFITS

A. TOTAL DISABILITY BENEFITS

- (1) If **Injury** or **Illness** to an **Insured Person** results in **Total Disability**, **We** will pay the Total Disability Weekly Income Benefit shown in the **Schedule** for the first 28 days of **Total Disability**.
- (2) If **Total Disability** continues beyond 28 days, **We** will pay 100% of the difference between the **Insured Person's Average Weekly Wage** and any disability income benefits received by the **Insured Person** from any Workers' Compensation act or similar law and **Other Valid and Collectible Insurance**, not to exceed the Total Disability Maximum Weekly Amount shown in the **Schedule**, for each week the **Insured Person** is **Totally Disabled** up to a maximum of five years (260 weeks).
- (3) The minimum benefit payable for **Total Disability** will be the Total Disability Minimum Weekly Amount shown in the **Schedule**.
- (4) If an **Insured Person** is approved for disability retirement or otherwise retires, all eligibility for **Total Disability** terminates on the effective date of such retirement.

B. PARTIAL DISABILITY BENEFITS

- (1) If **Injury** or **Illness** to an **Insured Person** results in **Partial Disability**, **We** will pay the Partial Disability Weekly Income Benefit shown in the **Schedule** for the first 28 days of **Partial Disability**.
- (2) If **Partial Disability** continues beyond 28 days, **We** will pay 50% of the difference between the **Insured Person's Average Weekly Wage** and any disability income benefits received by the **Insured Person** from any Workers' Compensation act or similar law and **Other Valid and Collectible Insurance**, not to exceed the Partial Disability Maximum Weekly Amount shown in the **Schedule**, for each week the **Insured Person** is **Partially Disabled** up to a maximum of 52 weeks.
- (3) The minimum benefit payable for **Partial Disability** will be the Partial Disability Minimum Weekly Amount shown in the **Schedule**.
- (4) If an **Insured Person** is approved for disability retirement or otherwise retires, all eligibility for **Partial Disability** terminates on the effective date of such retirement.

C. DISABILITY BENEFITS GENERAL

If an **Insured Person** is **Totally Disabled** or **Partially Disabled** for less than a week, **We** will pay 1/7 of

the benefit otherwise payable for each full day the **Insured Person** is so disabled.

The amount of Total Disability Benefits or Partial Disability Benefits payable to an **Insured Person** who is **Totally Disabled** or **Partially Disabled** may be increased after Total Disability Benefits or Partial Disability Benefits have been paid to that **Insured Person** for at least 52 consecutive weeks. The increase will equal the percentage increase, if any, in the **Consumer Price Index** for the preceding calendar year. The increase will apply to either the **Insured Person's Average Weekly Wage** at the time of the **Covered Activity** which caused the **Injury** or **Illness**, or to the Total Disability Benefit or Partial Disability Benefit, whichever results in the higher benefit to the **Insured Person**. Any increase in benefits will become effective on July 1 next following the 52 week benefit period. Successive annual increases, if any, on July 1 of each subsequent year will be compounded.

In the event that benefits are payable for both **Total Disability** and **Partial Disability** resulting from **Injury** or **Illness** sustained while participating in the same **Covered Activity**, the maximum benefit period for all benefits is five years (260 weeks).

Periods of **Total Disability** or **Partial Disability** separated by less than five years (260 weeks) will be considered one period of disability unless due to separate and unrelated causes.

PART IV. OCCUPATIONAL RETRAINING BENEFIT

We will pay for "Covered Retraining Expenses", up to the Occupational Retraining Benefit Maximum Amount shown in the **Schedule**, if, as a result of **Injury** or **Illness**, an **Insured Person** is not able to hold a **Gainful Occupation** and chooses to enroll in an institution of higher learning or professional or trade training program. The objective of any professional or trade training program must be to return the **Insured Person** to work in an occupation to which he/she is suited. The professional or trade training program must be agreed upon by **Us** and the **Insured Person**.

We will pay any "Covered Retraining Expenses" incurred by an **Insured Person** in excess of benefits paid or payable under any Worker's Compensation act or similar law, no fault automobile insurance or similar law, and any **Other Valid and Collectible Insurance**.

"**Covered Retraining Expenses**" includes, but is not limited to, expenses for tuition, books, and any other training materials required by the institution of higher learning or professional or trade training program.

PART V. MEDICAL EXPENSE BENEFITS

A. MEDICAL EXPENSE BENEFIT

We will pay the **Reasonable and Customary Expenses** incurred by an **Insured Person** as a result of an **Injury** or **Illness** for necessary:

- (1) medical, **Hospital** or surgical treatment;
- (2) "Home Health Care";
- (3) nursing services prescribed and monitored by a **Physician**;
- (4) Post-exposure Prophylaxis Protocol (PEP) treatment, when such treatment is advised by the attending **Physician**;
- (5) **Infectious Disease** screening test(s); or
- (6) Post-exposure preventive inoculations as a result of participation in a **Covered Activity**.

We will pay the medical expense benefits subject to the **Policyholder's** choice of 1, 2, or 3 below:

- (1) If “1” in the **Schedule** is marked with an “X”, **We** will pay any covered medical expenses incurred by an **Insured Person** in excess of benefits paid or payable under any Workers’ Compensation act or similar law, or no fault automobile insurance plan or similar law. If benefits are not payable under the applicable Workers’ Compensation act or similar law, but are covered under the policy, **We** will pay such benefits.
- (2) If “2” in the **Schedule** is marked with an “X”, **We** will pay any covered medical expenses incurred by an **Insured Person** in excess of benefits paid or payable under any Workers’ Compensation act or similar law, no fault automobile insurance plan or similar law, and any **Other Valid and Collectible Insurance**.
- (3) If “3” in the **Schedule** is marked with an “X”, **We** will pay any covered medical expenses incurred by an **Insured Person** on a primary basis regardless of benefits paid or payable under any other group insurance, no fault automobile insurance plan or similar law, or any Workers’ Compensation act or similar law.

All medical expense benefits will be paid subject to the terms and limits of each applicable part.

We will not pay more than the Medical Expense Maximum Amount shown in the **Schedule** for any one **Injury** or **Illness**.

“**Home Health Care**” means those nursing and other home health care services provided to an **Insured Person** in his or her place of residence. **Home Health Care** must be: (1) performed by a “Home Health Care Practitioner”; (2) in lieu of confinement in a **Hospital** or nursing facility; and (3) pursuant to the orders of the attending **Physician**. Such attending **Physician’s** orders must be written and include a plan of care which must be reviewed and approved by the **Physician**.

“**Home Health Care Practitioner**” means a nurse, medical social worker, home health aide, physical therapist, or other medical practitioner. However, no provider will be considered a **Home Health Care Practitioner** unless such practitioner is: (1) duly licensed and/or certified in compliance with all applicable laws and regulations to provide the care received; and (2) not an **Insured Person** or an **Immediate Family Member**.

B. COSMETIC PLASTIC SURGERY BENEFIT

We will pay the **Reasonable and Customary Expense(s)** incurred if an **Insured Person** requires skin grafting or plastic surgery due to an **Injury** for which Medical Expense Benefits are paid or payable. **We** will not pay more than the Cosmetic Plastic Surgery Maximum Amount shown in the **Schedule** for any one **Injury**.

C. POST TRAUMATIC STRESS DISORDER BENEFIT

We will pay the **Reasonable and Customary Expense(s)** incurred, if, as the result of participation in a specific **Covered Activity** in which a **Traumatic Incident** occurred while coverage under this policy is in force, an **Insured Person** requires medical treatment for a **Post-Traumatic Stress Disorder**. Treatment must be prescribed and monitored by a **Physician**. **We** will not pay more than the Post Traumatic Stress Disorder Maximum Amount shown in the **Schedule** for each **Insured Person** for any one **Covered Activity**.

D. CRITICAL INCIDENT STRESS MANAGEMENT BENEFIT

We will pay the reasonable expenses incurred by a “Critical Incident Stress Management Team” when such services are: (1) requested and authorized by the **Policyholder**; and (2) are required as a result of

the **Insured Person's** participation in a specific **Covered Activity** in which a **Traumatic Incident** occurred while coverage under this policy is in force. Covered expenses are those for necessary transportation, meals, and lodging. **We** will not pay more than the Critical Incident Stress Management Maximum Amount which is shown in the **Schedule** regardless of the number of **Insured Persons** treated.

“Critical Incident Stress Management Team (CISMT)” means a formally organized group of mental health professionals and peer support individuals trained to provide support services to emergency service personnel. Such support services include stress debriefing, defusing, demobilization, stress education, spousal support, one-on-one interviews, or on the scene support.

E. FAMILY EXPENSE BENEFIT

If an **Insured Person** requires **Hospital** confinement for three (3) or more consecutive days for an **Injury** or **Illness**, **We** will pay the Family Expense Benefit shown in the **Schedule** for each day of such **Hospital** confinement. This benefit will be payable retroactive to the first day of confinement, after the **Insured Person** has been confined for three (3) consecutive days.

After such **Hospital** confinement, **We** will also pay 50% of the Family Expense Benefit shown in the **Schedule** for each day an **Insured Person** participates in **Out-Patient Physical Therapy** as a result of such **Injury** or **Illness**.

The Family Expense Benefit will be payable for a combined maximum of 26 weeks for any one **Injury** or **Illness** regardless of whether it is paid at 100% or 50%.

PART VI. FELONIOUS ASSAULT BENEFIT

If this Felonious Assault Benefit is selected by the **Policyholder** as indicated in the **Schedule**, **We** will pay a benefit when the **Insured Person** suffers as a result of a “Felonious Assault” that is directed at the **Insured Person** while he or she is participating in a **Covered Activity**, one or more losses for which benefits are payable under the Accidental Death Indemnity Benefit, Accidental Dismemberment Benefit, Cosmetic Disfigurement Resulting from Burns Benefit, Injury Permanent Impairment Benefit, Heart Permanent Impairment Benefit, Illness Permanent Impairment Benefit, or Vision Impairment Benefit provided by the policy.

The amount payable is an additional 50% of the total amount payable under all the benefits specified above. Only one benefit is payable for all losses as a result of the same “Felonious Assault”.

This benefit is not applicable if the **Insured Person** is a police officer.

“Felonious Assault” means any willful or unlawful use of force upon the **Insured Person**: (1) with the intent to cause bodily injury to the **Insured Person**; and (2) that results in bodily harm to the **Insured Person**; and (3) that is a felony or a misdemeanor in the jurisdiction in which it occurs.

PART VII. HOME ALTERATION AND VEHICLE MODIFICATION BENEFIT

If an **Insured Person**:

- (1) suffers an **Injury** or **Illness** that is payable under the policy and which results in a permanent and irrevocable loss;
- (2) did not, prior to the date of the **Covered Activity**, require alterations to the home and/or modifications to the vehicle; and

- (3) as a direct result of such **Injury** or **Illness** is now required to make alterations to the home and/or modifications to the vehicle;

We will pay the Home Alteration and Vehicle Modification Benefit for “Home Alteration and Vehicle Modification Expenses” that are incurred within one year after the date of the **Injury** or **Illness**, up to the Home Alteration and Vehicle Modification Maximum Amount shown in the **Schedule**, for all such losses caused by the same **Injury** or **Illness**.

We will pay any “Home Alteration and Vehicle Modification Expenses” incurred by an **Insured Person** in excess of benefits paid or payable under any Workers’ Compensation act or similar law, no fault automobile insurance plan or similar law, and any **Other Valid and Collectible Insurance**.

“**Home Alteration and Vehicle Modification Expenses**” means one-time expenses that:

- (1) are charged for:
 - (a) alterations to the **Insured Person’s** residence that are necessary to make the residence accessible and habitable for an impaired individual; and
 - (b) modifications to a motor vehicle owned or leased by the **Insured Person** or modifications to a motor vehicle newly purchased for the **Insured Person** that are necessary to make the vehicle accessible to and/or drivable by the **Insured Person**; and
- (2) do not include charges that would not have been made if no insurance existed; and
- (3) do not exceed the usual level of charges for similar alterations and modifications in the locality where the expense is incurred;

but only if the alterations to the **Insured Person’s** residence and the modifications to his or her motor vehicle are:

- (1) made on behalf of the **Insured Person**;
- (2) in compliance with any applicable laws or requirements for approval by the appropriate government authorities; and
- (3) is agreed to and approved by **Us**.

PART VIII. OPTIONAL BENEFITS

A. WEEKLY HOSPITAL INDEMNITY BENEFIT

The Weekly Hospital Indemnity Benefit is only provided under the policy if it is selected by the **Policyholder**. If Weekly Income Benefits are payable under the policy, **We** will also pay the Weekly Hospital Indemnity Benefit shown in the **Schedule** if the **Insured Person** eligible to receive the Weekly Income Benefits requires **Hospital** confinement or **Out-Patient Physical Therapy** for the same **Injury** or **Illness**.

The Weekly Hospital Indemnity Benefit starts on the first day the **Insured Person** is confined to a **Hospital** or begins **Out-Patient Physical Therapy**. If benefits are payable for less than a full week, **We** will pay 1/7 of the Weekly Hospital Indemnity Benefit shown in the **Schedule** for each day the **Insured Person** is confined in the **Hospital** or receives **Out-Patient Physical Therapy**. This benefit will be limited to a maximum of 52 weeks for all **Injuries** or **Illnesses** resulting from the same **Covered Activity**.

If the **Insured Person** is in an intensive, cardiac or critical care unit, the Weekly Hospital Indemnity Benefit Amount shown in the **Schedule** is doubled.

B. ADDITIONAL DISABILITY WEEKLY BENEFIT

The Additional Disability Weekly Benefit is only provided under the policy if it is selected by the **Policyholder**. If an **Insured Person** becomes **Totally Disabled** and is eligible for Total Disability Benefits under the policy, **We** will pay a one time additional weekly benefit equal to the Additional Disability Weekly Benefit shown in the **Schedule** for the first week the **Insured Person** is **Totally Disabled**. If the **Insured Person** is **Totally Disabled** for less than one week, **We** will pay 1/7 of the Additional Disability Weekly Benefit for each full day of **Total Disability**. **We** will pay the Additional Disability Weekly Benefit in addition to any other weekly benefit payable under the policy.

C. 24-HOUR ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT

The 24-Hour Accidental Death and Dismemberment Benefit is only provided under the policy if it is selected by the **Policyholder** and a benefit amount is shown in the **Schedule**. It is payable if a "Covered Person" suffers an **Injury** at any time, whether it be during a **Covered Activity** or not, that results in the "Covered Person's" accidental death or dismemberment such that:

- (1) an Accidental Death Indemnity Benefit or an Accidental Dismemberment Benefit or a Vision Impairment Benefit is payable under the policy; or
- (2) an Accidental Death Indemnity Benefit or an Accidental Dismemberment Benefit or a Vision Impairment Benefit would otherwise be payable under the policy but for the **Injury** not being suffered during a **Covered Activity**.

Any 24-Hour Accidental Death and Dismemberment Benefit payable is in addition to any Accidental Death Indemnity Benefit or an Accidental Dismemberment Benefit or a Vision Impairment Benefit payable under the policy.

"**Covered Person**", as used in this Benefit, means all members who are listed on the **Policyholder's** roster. The roster will be maintained and periodically updated by the **Policyholder**. The roster will be kept on file by the **Policyholder**.

D. OFF-DUTY ACTIVITY ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT

The Off-Duty Activity Accidental Death and Dismemberment Benefit is only provided under the policy if it is selected by the **Policyholder** and a benefit amount is shown in the **Schedule**. It is payable if a "Covered Person" suffers an **Injury** during an activity that is not a **Covered Activity** that results in the "Covered Person's" accidental death or dismemberment. In the event of death the benefit amount payable will be equal to the Off-Duty Activity Accidental Death and Dismemberment Benefit indicated in the **Schedule**. In the event of dismemberment or vision loss the benefit amount payable will be calculated from the Off-Duty Activity Accidental Death and Dismemberment Benefit amount indicated in the **Schedule** and the Accidental Dismemberment Chart and the Vision Impairment Chart.

The Off-Duty Activity Accidental Death and Dismemberment Benefit is not available under the policy if the 24-Hour Accidental Death and Dismemberment Benefit is provided under the policy.

"**Covered Person**", as used in this Benefit, means all members who are listed on the **Policyholder's** roster. The roster will be maintained and periodically updated by the **Policyholder**. The roster will be kept on file by the **Policyholder**.

OTHER COVERAGE WITH THIS COMPANY

If the **Insured Person** is covered under more than one similar policy issued by **Us**, the total benefits payable

will not exceed those payable under the policy which provides the largest benefit.

EXCLUSIONS

We will not cover any loss caused by or resulting from:

- (1) suicide or any attempt at it, while sane or insane; or intentionally self-inflicted injuries while sane;
- (2) injuries that happen while flying except;
 - (a) as a passenger on a commercial aircraft;
 - (b) as a passenger on any aircraft while taking part in a **Covered Activity**;
- (3) injuries that happen while flying as a crew member, or during parachute jumps from the aircraft;
- (4) war or any act of war, whether declared or undeclared;
- (5) mental or emotional disorders, except as specifically provided for covered **Post Traumatic Stress Disorder**;
- (6) treatment of alcoholism or drug addiction and any complications arising therefrom, except loss caused by **Injury** sustained during and resulting from a **Covered Activity**;
- (7) illness, except as provided by the policy;
- (8) military service of any state or country;
- (9) any activity in football, ice hockey, field hockey, lacrosse, soccer and boxing or
- (10) any league sports event, except as covered under the Organized Team Sports Rider.

OTHER COVERAGE WITH THIS COMPANY

If the **Insured Person** is covered under more than one similar policy issued by **Us**, the total benefits payable will not exceed those payable under the policy which provides the largest benefit.

GENERAL PROVISIONS

Entire Contract; Changes: The policy, the application(s), the summary of coverage(s), and any attached riders, endorsements, amendments, and additional papers make up the entire contract between the **Policyholder** and **Us**.

No change in the policy and the summary of coverage shall be valid until approved by one of **Our** executive officers. Such approval must be noted on or attached to the policy or the summary of coverage. No agent may change or waive any of the provisions of the policy or the summary of coverage.

Statements: In the absence of fraud, all statements made by the **Policyholder** or any **Insured Person** will be considered representations and not warranties. No statement will be used to void the insurance or reduce benefits unless they appear in a written instrument signed by the **Policyholder** unless a copy of the statement is furnished to the **Insured Person** or his or her beneficiary or personal representative.

Incontestability: The validity of this policy will not be contested after it has been in force for two year(s) from the Policy Effective Date shown in the **Schedule**, except as to nonpayment of premiums.

Grace Period: The policy has a 31 day grace period. This means if the premium is not paid on or before the date it is due, it may be paid during the following 31 days. During the grace period the policy will remain in force.

Notice of Claim: Written notice of claim must be given to **Us** within 30 days after a covered loss occurs, or as soon thereafter as reasonably possible. The notice can be given by or on behalf of the **Insured Person** to **Us**

at **Our** Executive Offices or to one of **Our** authorized agents with sufficient information to identify the **Insured Person**, shall be deemed notice to **Us**.

Claim Forms: When **We** receive the written notice of claim, **We** will send the claimant forms for filing proof of loss. If these forms are not furnished within 15 days after receipt of such notice, the claimant will need to meet the proof of loss requirements by giving **Us** written proof of the occurrence, the nature, and the extent of the loss within the time limit stated in the "Proof of Loss" Section. The notice should include the **Insured Person's** name, the **Policyholder's** name, and the **Policy Number**.

Proof of Loss: If the policy provides for periodic payment for a continuing loss, **We** must be given written proof within 90 days after the end of each period for which **We** are liable. For any other loss, **We** must be given written proof within 90 days after that loss. If it was not reasonably possible to give written proof in the time required, **We** will not reduce or deny the claim for this reason, if the proof is filed as soon as reasonably possible. However, proof must be given as soon as reasonably possible.

Time of Payment of Claims: When **We** receive written proof of loss, **We** will pay any benefits due. Benefits that provide for periodic payment will be paid at least monthly. When **Our** liability ends, **We** will pay any remaining balance as soon as **We** receive written proof of loss.

Payment of Claims: Any Loss of Life Benefit will be paid in accordance with the beneficiary designation on record with **Us** or the **Policyholder**.

If no beneficiary is named, Loss of Life Benefits will be paid to the first surviving class of the following classes: the **Insured Person's** (1) spouse; (2) child(ren); (3) parents; or (4) brothers or sisters. Otherwise, **We** will pay benefits to the **Insured Person's** estate.

All other benefits are payable to the **Insured Person**, unless otherwise indicated in the policy. **We** may pay all or a part of any benefits for health care services directly to the provider. **We** cannot require that the service be given by a certain provider.

If the **Policyholder** requests, **We** may (at **Our** option) pay benefits to the **Policyholder**. The **Policyholder** will then pay the **Insured Person** or beneficiary entitled to receive the benefits.

Any payment **We** make in good faith will end **Our** liability to the extent of the payment.

Physical Examination and Autopsy: **We**, at **Our** expense, have the right to have the **Insured Person** examined as often as reasonably necessary while a claim is pending under the policy. **We** may also have an autopsy performed unless prohibited by law.

Legal Actions: No legal action may be brought to recover on the policy within 60 days after written proof of loss has been given as required by the policy. No such action may be brought after three years from the time written proof of loss is required to be given.

Change of Beneficiary: The **Insured Person** can change the beneficiary at any time by sending a written notice to the **Policyholder** or **Us**. The beneficiary's consent is not required for this or any other change in the policy, unless the designation of the beneficiary is irrevocable.

Conformity with State Statutes: Any provision of the policy, which, on its effective date, is in conflict with the laws of the state in which the **Insured Person** resides on that date, is amended to conform to the minimum requirements of such laws.

Clerical Error: The insurance of any **Insured Person** will not be affected by a clerical error made by the **Policyholder** or **Us**. An error will not continue the insurance of an **Insured Person** beyond the date it would

end under the policy terms if the error had not been made.

Examination and Audit: **We** shall be permitted to examine and audit a **Policyholder's** records relating to the policy at: (1) any reasonable time during the policy term; and (2) within two years after the expiration of the policy or until all claims have been settled or adjusted, whichever is later.

New Entrants: New eligible persons added from time to time to the group of **Insured Persons** originally insured under this plan will be automatically covered under the policy.

Duty to Cooperate: The **Policyholder** will cooperate with **Us** and assist **Us**, as **We** request, in the investigation of any claim reported under the policy. The **Policyholder** will not voluntarily make payments, assume obligations, or incur expenses, except at the cost of the **Policyholder**.

Not In Lieu Of Workers' Compensation: The policy is not a Workers' Compensation policy. It does not provide Workers' Compensation Benefits.

Noncompliance with Policy Requirements: Any express waiver by **Us** of any requirements of the policy will not constitute a continuing waiver of such requirements. Any failure by **Us** to insist upon compliance with any policy provision will not operate as a waiver or amendment of that provision.

Misstatement of Age: If the benefits for which the **Insured Person** is insured are based on age and the **Insured Person** has misstated his or her age, there will be an adjustment of said benefit based on his or her true age. **We** may require satisfactory proof of age before paying any claim.

Assignment: The policy is non-assignable. An **Insured Person** may not assign any of his or her rights, privileges or benefits under the policy.



AIG Domestic Accident & Health Division

A Division of the AIG Companies®

NATIONAL UNION FIRE INSURANCE COMPANY OF PITTSBURGH, PA.

Executive Offices: 70 Pine Street, New York, NY 10270

(212) 770-7000

(a capital stock company, herein referred to as the Company)

APPLICATION FOR BLANKET ACCIDENT AND SICKNESS INSURANCE

Application for a plan of accident and sickness is hereby made by:

(Name of [Policyholder][Participating Organization])

to National Union Fire Insurance Company of Pittsburgh, Pa. for coverage under Blanket Accident and Sickness Master Policy Form V40001NUFIC as described in Proposal Number [xxx] a copy of which is attached to and made a part of this application.

Policy Effective Date: [Month Day, Year] at 12:01 A.M. [time zone]

Policy Termination Date: [Month Day, Year] at 12:01 A.M. [time zone]

The following changes in limits or coverage from the above mentioned Proposal Number are hereby requested:

NO CHANGES

The above named entity hereby acknowledges that the changes shown above may result in a change of premium from that which was previously quoted.

The above named entity hereby understands that this application for accident and sickness coverage is subject to approval of the Company.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.^[e1]

(Signed by Authorized Representative)

(Title of Authorized Representative)

(Date)

Signed by Licensed Resident Agent
(Where Required by law)



AIG Domestic Accident & Health Division

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NATIONAL UNION FIRE INSURANCE COMPANY OF PITTSBURGH, PA.

Executive Offices: 70 Pine Street, New York, NY 10270

(212) 770-7000

(a capital stock company, herein referred to as the Company)

Policyholder: [_____]
Participating Organization: [_____]
Policy Number: [_____]

PARTICIPATING ORGANIZATION ENDORSEMENT

This endorsement is attached to and made part of the policy and summary of coverage [] as of the Policy Effective Date shown in the Schedule [] effective [Month Day, Year]. It applies only with respect to Injuries and Illnesses that occur on or after that date. It is subject to all of the provisions, limitations and exclusions of the policy except as they are specifically modified by this endorsement.

- 1. All references in the policy, application, the summary of coverage(s), rider(s), or endorsement(s) to the "Policyholder" (except as shown in the Schedule), the "Policy Effective Date", the "Policy Termination Date", and the "policy anniversary date" may also, where applicable, mean the "Participating Organization", the "Participating Organization's Effective Date", the "Participating Organization's Termination Date", and the "participating organization's anniversary date" respectively.
- 2. The following sections are hereby added to the policy:

PARTICIPATING ORGANIZATION EFFECTIVE AND TERMINATION DATES

Effective Date. A Participating Organization's coverage under the policy begins on the later of: (1) the Participating Organization Effective Date shown in the Application at 12:01 AM at the address of the Participating Organization shown in the Schedule; or (2) the Policy Effective Date shown in the Schedule.

Termination Date. We may terminate the Participating Organization's coverage under the policy by giving 30 days advance notice in writing to the Participating Organization. The Participating Organization's coverage under the policy may also, at any time, be terminated by the mutual written consent of Us and the Participating Organization. Termination of the Participating Organization's coverage takes effect at 12:01 AM at the Participating Organization's address on the date of termination.

PARTICIPATING ORGANIZATION PREMIUM

Premiums. Premiums are payable to Us at the rates described in the Premium section of the Schedule. We may also change the required premiums at any time when any change in coverage affecting premiums is made in this policy.

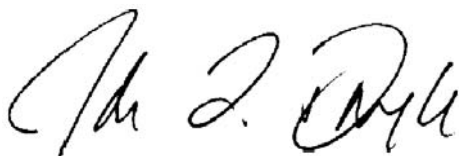
- 3. The following language applies to each summary of coverage, rider and endorsement attached to the policy:

Any benefits included in the summary of coverage, riders and endorsement attached to the policy apply only with respect to **Injuries**, and **Illnesses**, and losses of life, and impairments that occur on or after the later of: (1) the effective date of each rider or endorsement; or (2) the effective date of the **Participating Organization's** coverage under the policy. Each benefit applies with respect to a **Participating Organization's** coverage under the policy only if the **Participating Organization** has elected the coverage described in each summary of coverage, rider or endorsement as indicated in the proposal attached to the Application prepared for the Participating Organization.

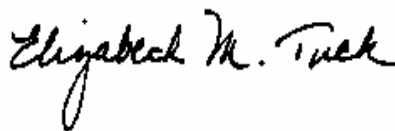
This Endorsement takes effect on [Month Day, Year] at 12:01 A.M., and it expires concurrently with the policy and is subject to all of the provisions, definitions, limitations, and conditions of the policy not inconsistent herewith.

Attached to and made a part of Policy No. [Insert Policy Number] issued to [Insert policyholder's name] by the National Union Fire Insurance Company of Pittsburgh, Pa. but the same shall not be binding on the Company unless countersigned by its duly authorized agent.

The President and Secretary of National Union Fire Insurance Company of Pittsburgh, Pa. witness this Endorsement:



President



Secretary

Countersigned by: _____

(Licensed Resident Agent)
(Where Required by Law)



AIG Domestic Accident & Health Division

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NATIONAL UNION FIRE INSURANCE COMPANY OF PITTSBURGH, PA.

Executive Offices: 70 Pine Street, New York, NY 10270

(212) 770-7000

(a capital stock company, herein referred to as the Company)

Policyholder: []

Policy Number: []

[POLICY/SUMMARY OF COVERAGE] AMENDMENT [No. 1]

{{THIS AMENDMENT FORM IS BEING FILED AS VARIABLE IN ITS ENTIRETY, BUT ONLY FOR THE PURPOSE OF AMENDING OR RENEWING THE POLICY/SUMMARY OF COVERAGE WITHIN THE PARAMETERS OF FILED VARIABLES. THIS ILLUSTRATES A BENEFIT CHANGE.}}

This Amendment is attached to and made a part of the [policy/summary of coverage [add appropriate summary of coverage form number]] effective [Month Day, Year] at 12:01 A.M. Any changes in coverage apply only with respect to covered losses that occur on or after that date. Any changes in premium apply as of the first premium due date on or after the effective date of this amendment. This amendment is subject to all the provisions, limitations and exclusions of the [policy/summary of coverage] except as they are specifically modified by this amendment.

In consideration of timely payment of the required premium, the minimum benefit payable for **Total Disability** will be the Total Disability Minimum Weekly Amount as shown below:

Total Disability Minimum Weekly Amount.....[\$]

The President and Secretary of National Union Fire Insurance Company of Pittsburgh, Pa. witness this Amendment:

President

Secretary

Countersigned by _____
Licensed Resident Agent
(Where required by law)



AIG Domestic Accident & Health Division

A Division of the AIG Companies®

NATIONAL UNION FIRE INSURANCE COMPANY OF PITTSBURGH, PA.

Executive Offices: 70 Pine Street, New York, NY 10270

(212) 770-7000

(a capital stock company, herein referred to as the Company)

Policyholder: []

Policy Number: []

CAREER PERSONNEL RIDER

This Rider is issued in consideration of the premium paid and is attached to and made part of the policy [] as of the Policy Effective Date shown in the **Schedule** [] effective [Month Day, Year]. It applies only with respect to **Injuries** and **Illnesses** that occur on or after that date. It is subject to all of the provisions, limitations and exclusions of the policy except as they are specifically modified by this rider. This rider amends the policy in the following manner:

- (1) The definition of **Insured Person** is amended to include those paid employees of a **Policyholder** (which is primarily staffed by volunteers). A paid employee is one who looks to the **Policyholder** for his or her primary means of living while he or she is acting within the scope of his or her employment. An employee will be deemed to look to the **Policyholder** for his or her primary source of income if he or she: (1) averages [25] hours or more employment per week; or (2) is salaried and works a schedule of more than [25] hours per week. The time frame used to determine the average hours or the salaried schedule will be the same time frame used to calculate the **Average Weekly Wage**.
- (2) The Weekly Injury Permanent Impairment Benefit, the Optional Weekly Injury Permanent Impairment COLA Benefit, Transition Benefit, and Extended Total Disability Benefit are hereby deleted in their entirety for paid employees.
- (3) The Continuation of Health Insurance Premium Benefit applies only if the paid employee does not receive health insurance benefits from the **Policyholder**.
- (4) In no event will coverage provided to such **Insured Persons** by way of this rider be in lieu of any worker's compensation act or similar law.

The President and Secretary of National Union Fire Insurance Company of Pittsburgh, Pa. witness this rider:

President

Secretary



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(a capital stock company, herein referred to as the Company)

Policyholder: []

Policy Number: []

AUXILIARY POLICE ENDORSEMENT

This endorsement is issued in consideration of the premium paid and is attached to and made a part of the policy [] as of the Policy Effective Date shown in the **Schedule**. [] effective [Month Day, Year]. [] It applies only with respect to **Injuries** and **Illnesses** that occur on or after that date. It is subject to all of the provisions, limitations and exclusions of the policy except as they are specifically modified by this endorsement. This endorsement amends the policy in the following manner:

A. The **DEFINITIONS** section as shown in the summary is modified as follows:

(1) The definition of **Covered Activity** is hereby deleted in its entirety and replaced by the following:

Covered Activity means a 'normal duty of a member' as defined by the written regulations of the department and includes activities and the travel to and from these activities such as, but not limited to: crowd control; accident investigation; making arrests and performing search and seizures of persons or property if properly certified; security for school corporations; approved classroom or field training activities in preparation for appointment; and during the probationary period.

(2) The definition of **Insured Person** is hereby deleted in its entirety and replaced by the following:

Insured Person means [Police Reserve Officers]¹ on file with the governing entity. All officers and reserve law enforcement members must be appointed officers or members. Such persons have completed, or are actively enrolled/participating in, the training and probationary period specified by the written regulations of the department.

[B]. The **Weekly Injury Permanent Impairment Benefit** as shown in the summary is hereby deleted in its entirety. []²

[C]. The **EXCLUSIONS** section in the summary is hereby amended to include the following exclusion:

[(10)] **Injury** or **Illness** caused by making an arrest, conducting a search or seizure, or as a result of carrying a firearm when the **Insured Person** has not completed the appropriate written training requirements associated with these activities.

The President and Secretary of National Union Fire Insurance Company of Pittsburgh, Pa. witness this endorsement:

President

Secretary



AIG Domestic Accident & Health Division

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NATIONAL UNION FIRE INSURANCE COMPANY OF PITTSBURGH, PA.

Executive Offices: 70 Pine Street, New York, NY 10270

(212) 770-7000

(a capital stock company, herein referred to as the Company)

Policyholder: []

Policy Number: []

FIRE DEPARTMENTS WITH AUXILIARY POLICE ENDORSEMENT

This endorsement is issued in consideration of the premium paid and is attached to and made a part of the policy [] as of the Policy Effective Date shown in the **Schedule**. [] effective [Month Day, Year]. [] It applies only with respect to **Injuries** and **Illnesses** that occur on or after that date. It is subject to all of the provisions, limitations and exclusions of the policy except as they are specifically modified by this endorsement. This endorsement amends the policy in the following manner:

A. The **DEFINITIONS** section as shown in the summary is modified as follows:

(1) The definition of **Covered Activity** is hereby amended to include the following:

Covered Activity also includes a 'normal duty of a member' as defined by the written regulations of the department and includes activities and the travel to and from these activities such as, but not limited to: crowd control; accident investigation; making arrests and performing search and seizures of persons or property if properly certified; security for school corporations; approved classroom or field training activities in preparation for appointment; and during the probationary period.

(2) The definition of **Insured Person** is hereby amended to include the following:

Insured Person also includes [Police Reserve Officers]¹ on file with the governing entity. All officers and reserve law enforcement members must be appointed officers or members. Such persons have completed, or are actively enrolled/participating in, the training and probationary period specified by the written regulations of the department.

[B]. The **Weekly Injury Permanent Impairment Benefit** as shown in the summary is hereby deleted in its entirety.²

[C]. The **EXCLUSIONS** section as shown in the summary is hereby amended to include the following exclusion:

[(10)] **Injury** or **Illness** caused by making an arrest, conducting a search or seizure, or as a result of carrying a firearm when the **Insured Person** has not completed the appropriate written training requirements associated with these activities.

The President and Secretary of National Union Fire Insurance Company of Pittsburgh, Pa. witness this endorsement:

President

Secretary



AIG Domestic Accident & Health Division

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NATIONAL UNION FIRE INSURANCE COMPANY OF PITTSBURGH, PA.

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(212) 770-7000

(a capital stock company, herein referred to as the Company)

Policyholder: []

Policy Number: []

OPTIONAL BENEFITS FOR ORGANIZED TEAM SPORTS RIDER

This rider is issued in consideration of the premium paid and is attached to and made a part of the policy [] as of the Policy Effective Date shown in the **Schedule**. [] effective [Month Day, Year]. [] It applies only with respect to **Injuries** that occur on or after that date. This rider is subject to all the provisions, limitations and exclusions of the policy except as they are specifically modified by this rider. If there is a conflict between the policy and the rider, the terms of this rider will govern.

We will pay the benefits described below if "Injury" or loss of life to an **Insured Person** results from participation in (including travel directly to and from) a specific organized team league event, including a game or practice.

A. ACCIDENTAL DEATH INDEMNITY BENEFIT

We will pay the Accidental Death Indemnity Benefit shown below if "Injury" to an **Insured Person** results in the **Insured Person's** death.

Accidental Death Indemnity Benefit.....[\$]

B. ACCIDENTAL DISMEMBERMENT BENEFIT

If "Injury" to an **Insured Person** shall result in any one of the "Losses" listed below, **We** will pay the indicated percentage of the Accidental Dismemberment Principal Sum shown below for the "Loss" suffered. If the **Insured Person** suffers more than one "Loss" as a result of any one accident, only one amount, the largest, will be paid.

Accidental Dismemberment Chart

| <u>For Loss of:</u> | <u>% of Accidental Dismemberment Principal Sum Payable</u> |
|--|--|
| Both Hands or Both Feet | 100 |
| One Hand and One Foot..... | 100 |
| Entire Sight of Both Eyes | 100 |
| One Hand and Entire Sight of One Eye | 100 |
| One Foot and Entire Sight of One Eye..... | 100 |
| Speech and Hearing | 100 |
| One Arm or One Leg..... | 75 |
| Speech or Hearing | 50 |
| One Hand or One Foot..... | 50 |
| Entire Sight of One Eye..... | 50 |

| | |
|------------------------------------|----|
| Both Thumbs | 10 |
| One Thumb | 5 |
| Each Joint of a Finger or Toe..... | 1 |

Accidental Dismemberment Principal Sum.....[\$]

“**Loss**” means, with reference to the foot, a complete severance through or above the ankle joint; with reference to the hand, the complete severance of the distal, proximal or medial phalanx of four fingers; with reference to the arm or leg, the complete severance through or above the elbow or knee joint; with reference to the thumb, the complete severance at the metacarpophalangeal joint; and with reference to a joint of a finger or toe, the complete severance of a distal, proximal or (where applicable) medial phalanx. “**Loss**” of speech or hearing means the total and irrecoverable loss of speech and/or hearing. “**Loss**” of sight means the total and irrecoverable loss of sight.

C. TOTAL DISABILITY BENEFIT

- (1) If “Injury” to an **Insured Person** results in **Total Disability**, **We** will pay the Total Disability Weekly Income Benefit shown below for the first 28 days of **Total Disability**.

Total Disability Weekly Income Benefit (first 28 days)[\$]

- (2) If **Total Disability** continues beyond 28 days, **We** will pay 100% of the difference between the **Insured Person's Average Weekly Wage** and any disability income benefits received by the **Insured Person** from any Workers’ Compensation act or similar law and **Other Valid and Collectible Insurance**, not to exceed the Total Disability Maximum Weekly Amount shown in the **Schedule**, for each week the **Insured Person** is **Totally Disabled** up to a maximum of [104] weeks.

Total Disability Maximum Weekly Amount (after 28 days).....[\$]

- (3) The minimum benefit payable for **Total Disability** will be the Total Disability Minimum Weekly Amount shown below.

Total Disability Minimum Weekly Amount.....[\$]

- (4) If an **Insured Person** is approved for disability retirement or otherwise retires, all eligibility for **Total Disability** terminates on the effective date of such retirement.

If an **Insured Person** is **Totally Disabled** for less than a week, **We** will pay 1/7 of the benefit otherwise payable for each full day the **Insured Person** is so disabled.

The amount of Total Disability Benefits payable to an **Insured Person** who is **Totally Disabled** may be increased after Total Disability Benefits have been paid to that **Insured Person** for at least 52 consecutive weeks. The increase will equal the percentage increase, if any, in the **Consumer Price Index** for the preceding calendar year. The increase will apply to either the **Insured Person's Average Weekly Wage** at the time of the organized team sport which caused the “Injury”, or to the Total Disability Benefit, whichever results in the higher benefit to the **Insured Person**. Any increase in benefits will become effective on July 1 next following the 52 week benefit period. Successive annual increases, if any, on July 1 of each subsequent year will be compounded.

We will pay up to a maximum of [104] weeks) for any one accident.

Periods of **Total Disability** separated by less than five years (260 weeks) will be considered one period of disability unless due to separate and unrelated causes.

D. MEDICAL EXPENSE BENEFITS

We will pay the **Reasonable and Customary Expenses** incurred by an **Insured Person** as a result of an "Injury" for necessary:

- (1) medical, **Hospital** or surgical treatment;
- (2) **Home Health Care**;
- (3) nursing services prescribed and monitored by a **Physician**.

We will pay the medical expense benefit subject to the **Policyholder's** choice of the Medical Expense Benefit Options listed below:

- ☐ We will pay any covered medical expenses incurred by an **Insured Person** in excess of benefits paid or payable under any Workers Compensation act or similar law, or no fault automobile insurance plan or similar law. If benefits are not payable under the applicable Workers' Compensation act or similar law, but are covered under the policy, **We** will pay such benefits.
- ☐ We will pay any covered medical expenses incurred by an **Insured Person** in excess of benefits paid or payable under any Worker's Compensation act or similar law, no fault automobile insurance plan or similar law, and any **Other Valid and Collectible Insurance**.
- ☐ We will pay any covered medical expenses incurred by an **Insured Person** on a primary basis regardless of benefits paid or payable under any other group insurance, no fault automobile insurance plan or similar law, or any Workers' Compensation act or similar law.

All medical expense benefits will be paid subject to the terms and limits of each applicable part.

We will not pay more than the Medical Expense Maximum Amount shown below for any one accident.

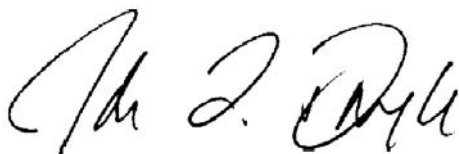
Medical Expense Maximum Amount.....**[\$]**

[Deductible Amount (if applicable)] **[\$]**

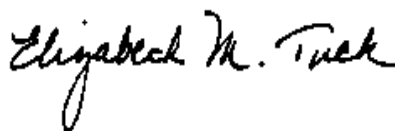
Total Additional Premium.....**[\$]**

"Injury" as used in this rider, means accidental bodily injury sustained by the **Insured Person**: (1) during and resulting from an **Insured Person's** participation in an organized team sport while coverage under this rider is in force as to the **Insured Person**; (2) which directly and independently causes a loss to the **Insured Person**; and (3) which is not otherwise defined as an **Illness**. The term "Injury" includes, but is not limited to, hernia, back strain or sprain, heat exhaustion, and over-exertion. The term "Injury", for the purposes of this policy, shall not include human immunodeficiency virus (HIV), acquired immune deficiency syndrome (AIDS) or AIDS related complex (ARC), or any heart or circulatory malfunction.

The President and Secretary of National Union Fire Insurance Company of Pittsburgh, Pa. witness this rider:



President



Secretary



AIG Domestic Accident & Health Division

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Executive Offices: 70 Pine Street, New York, NY 10270

(212) 770-7000

(a capital stock company, herein referred to as the Company)

Policyholder: []

Policy Number: []

OPTIONAL BENEFITS FOR SPECIAL EVENTS RIDER

This Rider is issued in consideration of the premium paid and is attached to and made a part of the policy [] as of the Policy Effective Date shown in the **Schedule**. [] effective [Month Day, Year]. It applies only with respect to **Injuries** that occur on or after that date. This rider is subject to all the provisions, limitations and exclusions of the policy except as they are specifically modified by this rider. If there is a conflict between the Policy and this rider, the terms of this rider will govern.

We will pay the benefits described below if "Injury" to an **Insured Person** results from participation in (including travel directly to and from) in the following "Special Activity": []

A. TOTAL DISABILITY BENEFIT

- (1) If "Injury" to an **Insured Person** results in **Total Disability**, **We** will pay the Total Disability Weekly Income Benefit shown below for the first 28 days of **Total Disability**.

Total Disability Weekly Income Benefit (first 28 days) [\$]

- (2) If **Total Disability** continues beyond 28 days, **We** will pay 100% of the difference between the **Insured Person's Average Weekly Wage** and any disability income benefits received by the **Insured Person** from any Workers' Compensation act or similar law and **Other Valid and Collectible Insurance**, not to exceed the Total Disability Maximum Weekly Amount shown in the **Schedule**, for each week the **Insured Person** is **Totally Disabled** up to a maximum of [104] weeks.

Total Disability Maximum Weekly Amount (after 28 days) [\$]

- (3) The minimum benefit payable for **Total Disability** will be the Total Disability Minimum Weekly Amount shown below.

Total Disability Minimum Weekly Amount [\$]

- (4) If an **Insured Person** is approved for disability retirement or otherwise retires, all eligibility for **Total Disability** terminates on the effective date of such retirement.

If an **Insured Person** is **Totally Disabled** for less than a week, **We** will pay 1/7 of the benefit otherwise payable for each full day the **Insured Person** is so disabled.

The amount of Total Disability Benefits payable to an **Insured Person** who is **Totally Disabled** may be increased after Total Disability Benefits have been paid to that **Insured Person** for at least 52 consecutive

weeks. The increase will equal the percentage increase, if any, in the **Consumer Price Index** for the preceding calendar year. The increase will apply to either the **Insured Person's Average Weekly Wage** at the time of the "Special Activities" which caused the "Injury", or to the Total Disability Benefit, whichever results in the higher benefit to the **Insured Person**. Any increase in benefits will become effective on July 1 next following the 52 week benefit period. Successive annual increases, if any, on July 1 of each subsequent year will be compounded.

We will pay up to a maximum of **[104]** weeks for any one **Injury**.

Periods of **Total Disability** separated by less than five years (260 weeks) will be considered one period of disability unless due to separate and unrelated causes.

B. MEDICAL EXPENSE BENEFIT

We will pay the **Reasonable and Customary Expenses** incurred by an **Insured Person** as a result of an "Injury" for necessary:

- (1) medical, **Hospital** or surgical treatment;
- (2) **Home Health Care**;
- (3) nursing services prescribed and monitored by a **Physician**.

We will pay the medical expense benefit subject to the **Policyholder's** choice of the Medical Expense Benefit Options listed below:

- ☐ **We** will pay any covered medical expenses incurred by an **Insured Person** in excess of benefits paid or payable under any Workers' Compensation act or similar law, or no fault automobile insurance plan or similar law. If benefits are not payable under the applicable Workers' Compensation act or similar law, but are covered under the policy, **We** will pay such benefits.
- ☐ **We** will pay any covered medical expenses incurred by an **Insured Person** in excess of benefits paid or payable under any Workers' Compensation act or similar law, no fault automobile insurance plan or similar law, and any **Other Valid and Collectible Insurance**.
- ☐ **We** will pay any covered medical expenses incurred by an **Insured Person** on a primary basis regardless of benefits paid or payable under any other group insurance, no fault automobile insurance plan or similar law, or any Workers' Compensation act or similar law.

All medical expense benefits will be paid subject to the terms and limits of each applicable part.

We will not pay more than the Medical Expense Maximum Amount shown below for any one accident.

| | |
|--|---------------|
| Medical Expense Maximum Amount | [\$] |
| [Deductible Amount (if applicable)] | [\$] |
| Total Additional Premium | [\$] |

"Injury" as used in this rider, means accidental bodily injury sustained by the **Insured Person**: (1) during and resulting from an **Insured Person's** participation in a "Special Activity" while coverage under this rider is in force as to the **Insured Person**; (2) which directly and independently causes a loss to the **Insured Person**; and (3) which is not otherwise defined as an **Illness**. The term "Injury" includes, but is not limited to, hernia, back strain or sprain, heat exhaustion, and over-exertion. The term "Injury", for the purposes of this policy,

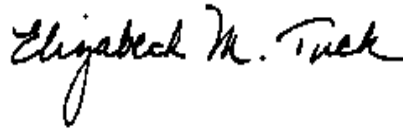
shall not include human immunodeficiency virus (HIV), acquired immune deficiency syndrome (AIDS) or AIDS related complex (ARC), or any heart or circulatory malfunction.

“Special Activity(ies)” as used in this rider, means participating in the specified event listed above.

The President and Secretary of National Union Fire Insurance Company of Pittsburgh, Pa. witness this rider:

A handwritten signature in black ink, appearing to read "John J. Doyle".

President

A handwritten signature in black ink, appearing to read "Elizabeth M. Tuck".

Secretary



AIG Domestic Accident & Health Division

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Executive Offices: 70 Pine Street, New York, NY 10270

(212) 770-7000

(a capital stock company, herein referred to as the Company)

Policyholder: []

Policy Number: []

OPTIONAL SUBROGATION RIDER

This rider is attached to and made a part of the policy [] as of the Policy Effective Date shown in the **Schedule.** [] effective [Month Day, Year]. [] It applies with respect to **Injuries** and **Illnesses** that occur on or after that date. This rider is subject to all of the provisions, limitations and exclusions of the policy except as they are specifically modified by this rider. If there is a conflict between the policy and the rider, the terms of the rider will govern.

To the extent that **We** pay for losses incurred, **We** may assume the rights and remedies of an **Insured Person** relating to such loss. The **Insured Person** agrees to assist **Us** in preserving those rights against those responsible for such loss, including but not limited to signing forms supplied by **Us**.

The President and Secretary of National Union Fire Insurance Company of Pittsburgh, Pa. witness this rider:

President

Secretary



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Executive Offices: 70 Pine Street, New York, NY 10270

(212) 770-7000

(a capital stock company, herein referred to as the Company)

Policyholder: []

Policy Number: []

PAYMENT OF CLAIMS RIDER

This Rider is attached to and made part of the policy [] as of the Policy Effective Date shown in the **Schedule**. [] effective [Month Day, Year]. [] It applies only with respect to **Injuries** and **Illnesses** that occur on or after that date. This rider is subject to all the provisions, and limitations and exclusions of the summary of coverage except as they are specifically modified by this rider. If there is a conflict between the summary of coverage and this rider, the terms of this rider will govern.

In accordance with the Payment of Claims provision in the summary of coverage if the **Policyholder** so requests, **We** may (at **Our** option) pay such benefits to the **Policyholder** for transmittal to the **Insured Person** or beneficiary entitled to receive the benefits.

All other terms and conditions of the policy and the summary of coverage remain the same.

Authorized Signature _____

Title _____ Date _____

Name of **Policyholder** _____

The President and Secretary of National Union Fire Insurance Company of Pittsburgh, Pa. witness this Rider:

President

Secretary



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Executive Offices: 70 Pine Street, New York, NY 10270

(212) 770-7000

(a capital stock company, herein referred to as the Company)

Policyholder: [ABC Incorporated]

Policy Number: [XXXXXX]

[Participating Organization: [XYZ Company]]

Amendatory Endorsement for Arkansas Residents

This Amendatory Endorsement is attached to and made part of the Summary of Coverage, form number V40004NUFIC [as of the Policy Effective Date shown in the Schedule of the Coverages][effective [Month Day, Year]]. It applies only with respect to **Illnesses** and/or **Injuries** on or after that date. It is subject to the provisions, benefits, and exclusions of the Policy except as they are specifically modified by this Amendatory Endorsement.

1. The “**Notice of Claim**” provision, appearing under the section entitled “**GENERAL PROVISIONS**”, is hereby deleted and replaced by the following:

Notice of Claim: Written notice of claim must be given to **Us** within 30 days after a covered loss occurs, or as soon thereafter as reasonably possible. The notice can be given by or on behalf of the **Insured Person** to **Us** at **Our** Executive Offices or to one of **Our** authorized agents with sufficient information to identify the **Insured Person**, shall be deemed notice to **Us**. If it was not reasonably possible to give written proof in the time required, **We** will not reduce or deny the claim for this reason, if the proof is filed as soon as reasonably possible.

2. The “**Proof of Loss**” provision, appearing under the section entitled “**GENERAL PROVISIONS**” is hereby deleted and replaced by the following:

Proof of Loss: If the policy provides for periodic payment for a continuing loss, **We** must be given written proof within 30 days after the end of each period for which **We** are liable and subsequent written proofs of eligibility must be furnished to **Us** at such intervals as **We** may reasonably require. For any other loss, **We** must be given written proof within 90 days after that loss. If it was not reasonably possible to give written proof in the time required, **We** will not reduce or deny the claim for this reason, if the proof is filed as soon as reasonably possible. However, proof must be given as soon as reasonably possible.

The President and Secretary of National Union Fire Insurance Company of Pittsburgh, PA witness this Endorsement:

President

Secretary



AIG Domestic Accident & Health Division

A Division of the AIG Companies®

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Executive Offices: 70 Pine Street, New York, NY 10270
(212) 770-7000

(a capital stock company, herein referred to as the Company)

Policyholder: [ABC Incorporated]

Policy Number: [XXXXXX]

[Participating Organization: [XYZ Company]]

Amendatory Endorsement for Arkansas Residents

This Amendatory Endorsement is attached to and made part of the Summary of Coverage, form number V40005NUFIC [as of the Policy Effective Date shown in the Schedule of the Coverages][effective [Month Day, Year]]. It applies only with respect to **Illnesses** and/or **Injuries** on or after that date. It is subject to the provisions, benefits, and exclusions of the Policy except as they are specifically modified by this Amendatory Endorsement.

1. The “**Notice of Claim**” provision, appearing under the section entitled “**GENERAL PROVISIONS**”, is hereby deleted and replaced by the following:

Notice of Claim: Written notice of claim must be given to **Us** within 30 days after a covered loss occurs, or as soon thereafter as reasonably possible. The notice can be given by or on behalf of the **Insured Person** to **Us** at **Our** Executive Offices or to one of **Our** authorized agents with sufficient information to identify the **Insured Person**, shall be deemed notice to **Us**. If it was not reasonably possible to give written proof in the time required, **We** will not reduce or deny the claim for this reason, if the proof is filed as soon as reasonably possible.

2. The “**Proof of Loss**” provision, appearing under the section entitled “**GENERAL PROVISIONS**” is hereby deleted and replaced by the following:

Proof of Loss: If the policy provides for periodic payment for a continuing loss, **We** must be given written proof within 30 days after the end of each period for which **We** are liable and subsequent written proofs of eligibility must be furnished to **Us** at such intervals as **We** may reasonably require. For any other loss, **We** must be given written proof within 90 days after that loss. If it was not reasonably possible to give written proof in the time required, **We** will not reduce or deny the claim for this reason, if the proof is filed as soon as reasonably possible. However, proof must be given as soon as reasonably possible.

The President and Secretary of National Union Fire Insurance Company of Pittsburgh, PA witness this Endorsement:

President

Secretary



AIG Domestic Accident & Health Division

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Executive Offices: 70 Pine Street, New York, NY 10270

(212) 770-7000

(a capital stock company, herein referred to as the Company)

Policyholder: []

Policy Number: []

CONTINUATION OF HEALTH INSURANCE PREMIUM BENEFIT RIDER (Career Members)

This rider is issued in consideration of the premium paid and is attached to and made a part of the policy [] as of the Policy Effective Date shown in the **Schedule**. [] effective [Month Day, Year]. It applies only with respect to **Injuries** and **Illnesses** that occur on or after that date. This rider is subject to all the provisions, limitations and exclusions of the policy except as they are specifically modified by this rider. If there is a conflict between the policy and the rider, the terms of this rider will govern.

We will pay a benefit equal to the "Continuation of Health Insurance Premium", up to \$12,000 per occurrence if: (1) as a result of **Injury** or **Illness**, an **Insured Person** becomes **Totally Disabled**; (2) **We** have paid six weeks of Total Disability Benefits under the policy; and (3) the **Insured Person** is responsible for his or her "Continuation of Health Insurance Premium". The **Insured Person** must submit to **Us** proof that the premium contribution was previously paid by the **Insured Person's** employer or by the **Insured Person** himself or herself. This coverage does not apply if the **Policyholder** provides health insurance benefits for the **Insured Person**. This benefit also does not apply for an **Insured Person** who is: (1) self employed under item 4 of the **Average Weekly Wage** definition; or (2) an officer or a partner in any organization that purchases health insurance for the **Insured Person**.

"Continuation of Health Insurance Premium" means payments by the **Insured Person** to maintain employer-provided individual or family health insurance, after the employer paid premium or contribution becomes the responsibility of the **Insured Person**.

The President and Secretary of National Union Fire Insurance Company of Pittsburgh, Pa. witness this rider:

President

Secretary

| | | | |
|---------------------------------|---|-------------------------------|---|
| <i>SERFF Tracking Number:</i> | <i>AGDE-126006827</i> | <i>State:</i> | <i>Arkansas</i> |
| <i>Filing Company:</i> | <i>National Union Fire Insurance Company of Pittsburgh, PA</i> | <i>State Tracking Number:</i> | <i>41906</i> |
| <i>Company Tracking Number:</i> | <i>V40004NUFIC(REV 01/09)/V40005NUFIC</i> | | |
| <i>TOI:</i> | <i>H04 Health - Blanket Accident/Sickness</i> | <i>Sub-TOI:</i> | <i>H04.000 Health - Blanket Accident/Sickness</i> |
| <i>Product Name:</i> | <i>Blanket Accident and Sickness</i> | | |
| <i>Project Name/Number:</i> | <i>Speciality Market Blanket A&S/V40004NUFIC(Rev 01/09)/V40005NUFIC</i> | | |

Rate Information

Rate data does NOT apply to filing.

SERFF Tracking Number: AGDE-126006827 State: Arkansas
 Filing Company: National Union Fire Insurance Company of Pittsburgh, PA State Tracking Number: 41906
 Company Tracking Number: V40004NUFIC(REV 01/09)/V40005NUFIC
 TOI: H04 Health - Blanket Accident/Sickness Sub-TOI: H04.000 Health - Blanket Accident/Sickness
 Product Name: Blanket Accident and Sickness
 Project Name/Number: Speciality Market Blanket A&S/V40004NUFIC(Rev 01/09)/V40005NUFIC

Supporting Document Schedules

Review Status:
Satisfied -Name: Flesch Certification Approved-Closed 01/29/2009

Comments:

(1) With respect to Rule & Regulation 19, neither our forms nor our underwriting practices discriminate against "sex".
 (3) In accordance with ACA 23-80-206 attached you will find the Flesch Score Readability Certification
 (4) In accordance with ACA 23-79-138 and bulletin 11-88 attached you will find a copy of the 'Consumer Information Notice'. This form is being submitted for informational purposes only.

Attachments:

AR-Service Info.pdf
 09-0126 Readability Cert.pdf

Review Status:
Bypassed -Name: Application Approved-Closed 01/29/2009
Bypass Reason: Application is included in the "Form Schedule" of this SERFF filing. The form number is V40002NUFIC-AR.

Comments:

Review Status:
Satisfied -Name: Coverage Territory Endorsement Approved-Closed 01/29/2009

Comments:

Please note that the attached form 'Coverage Territory Endorsement' (form number 89644 (7/05)) was approved by your department on June 19, 2007, on a general use basis for all of our companies and for all of our products, current and future. This form is being submitted with this filing only on an "Informational Basis".

Attachment:

89644(7-05).pdf

Review Status:
Satisfied -Name: Cover letter Approved-Closed 01/29/2009

Comments:

Attachment:

09-0127 Submission Letter.pdf

If you are having problems with your insurance company or agent, do not hesitate to contact the company or agent to resolve your problem:

INSURANCE COMPANY:

National Union Fire Insurance Company of Pittsburgh, Pa.
Customer Service
600 King Street
Wilmington, DE 198889
1-800-551-0824

INSURANCE AGENT:

[John Doe
XXX Any Street
Any City, Any State XXXXX]

If we at National Union Fire Insurance Company of Pittsburgh, Pa. fail to provide you with reasonable and adequate service you may contact the Office of the Commissioner of Insurance, a state agency which enforces Arkansas' insurance laws, and file a complaint. You can contact the Office of the Commissioner of Insurance at:

Arkansas Insurance Department
Consumer Services Division
1200 W. Third Street
Little Rock, AR 72201-1904
1-800-852-5494
1-501-371-2640
Fax Number: 1-501-371-2749
E-Mail: insurance.consumers@arkansas.gov
Web Site: www.insurance.arkansas.gov

STATE OF ARKANSAS

CERTIFICATION

This is to certify that the form number(s) listed below have achieved a Flesch Reading Ease score of least 40 and complies with the requirements of Ark. Stat. Ann. § 23-80-201 through § 23-80-208, cited as the Life and Accident and Health Insurance Policy Language Simplification Act.

| <u>Form Number</u> | <u>Form Name</u> | <u>Flesch Score</u> |
|------------------------|--|---------------------|
| V40004NUFIC(Rev 01/09) | Summary Of Coverage (Volunteer Members) | 50.0 |
| V40005NUFIC(Rev 01/09) | Summary Of Coverage (Career Members) | 50.0 |
| V40003NUFIC | Participating Organization Endorsement | 50.8 |
| V40006NUFIC | Policy/Summary of Coverage Amendment | 50.6 |
| V40007NUFIC(Rev 01/09) | Career Personnel Rider | 51.1 |
| V40008NUFIC | Auxiliary Police Endorsement | 50.7 |
| V40009NUFIC | Fire Department With Auxiliary Police Endorsement | 50.3 |
| V40010NUFIC(Rev 01/09) | Optional Benefits For Organized Team Sports Rider | 50.1 |
| V40011NUFIC(Rev 01/09) | Optional Benefits For Special Events Rider | 50.5 |
| V40012NUFIC | Optional Subrogation Rider | 56.9 |
| V40013NUFIC | Payment of Claims Rider | 55.3 |
| V40018NUFIC-AR | Amendatory Endorsement for Arkansas Residents (Volunteer Members) | 53.6 |
| V40019NUFIC-AR | Amendatory Endorsement for Arkansas Residents (Career Members) | 51.8 |
| V40020NUFIC | Continuation of Health Insurance Premium Benefit Rider (Career Members) | 50.2 |
| 89644 (7/05) | Coverage Territory Endorsement | 51.0 |

Michael F. McGarrity, Director of Products

January 26, 2009

Date

**THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT
CAREFULLY.**

ENDORSEMENT #

This endorsement, effective 12:01 A.M.

forms a part of Policy

No. issued to by National Union Fire Insurance
Company of Pittsburgh, PA

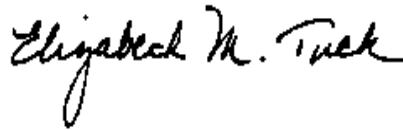
COVERAGE TERRITORY ENDORSEMENT

This endorsement modifies insurance provided under the following:

Payment of loss under this policy shall only be made in full compliance with all United States of America economic or trade sanction laws or regulations, including, but not limited to, sanctions, laws and regulations administered and enforced by the U.S. Treasury Department's Office of Foreign Assets Control ("OFAC").



President



Secretary



AIG Domestic Accident & Health Division

A Division of the AIG Companies®

**NATIONAL UNION FIRE INSURANCE
COMPANY OF PITTSBURGH, PA.**

Administrative Offices:

A&H Regulatory Affairs Department
Mailstop: PDV1
P.O. Box 667
Wilmington, DE 19899-9853

January 27, 2009

Honorable Jay Bradford
Insurance Commissioner
Arkansas Department of Insurance
Life & Health Division
1200 West Third Street
Little Rock, Arkansas 72201-1904

RE: National Union Fire Insurance Company of Pittsburgh, Pa.

NAIC # NUF 012-19445, **FEIN** 25-0687550

Blanket Accident and Health Insurance Program

| | |
|------------------------|---|
| V40002NUFIC-AR | Application for Blanket Accident And Sickness Insurance |
| V40003NUFIC | Participating Organization Endorsement |
| V40004NUFIC(Rev 01/09) | Summary Of Coverage (Volunteer Members) |
| V40005NUFIC(Rev 01/09) | Summary Of Coverage (Career Members) |
| V40006NUFIC | Policy/Summary of Coverage Amendment |
| V40007NUFIC(Rev 01/09) | Career Personnel Rider |
| V40008NUFIC | Auxiliary Police Endorsement |
| V40009NUFIC | Fire Department With Auxiliary Police Endorsement |
| V40010NUFIC(Rev 01/09) | Optional Benefits For Organized Team Sports Rider |
| V40011NUFIC(Rev 01/09) | Optional Benefits For Special Events Rider |
| V40012NUFIC | Optional Subrogation Rider |
| V40013NUFIC | Payment of Claims Rider |
| V40018NUFIC-AR | Amendatory Endorsement for Arkansas Residents (Volunteer Members) |
| V40019NUFIC-AR | Amendatory Endorsement for Arkansas Residents (Career Members) |
| V40020NUFIC | Continuation of Health Insurance Premium Benefit Rider (Career Members) |
| 89644 (7/05) | Coverage Territory Endorsement |
| | AR-SERVICE INFO (Rev 09/07) |

Out-of-State Form Filing

SERFF Tracking Number: AGDE-126006318

ATTN: Rosalind Minor

Senior Certified Rate & Form Analyst
Life & Health Division

Dear Commissioner Bowman:

National Union Fire Insurance Company of Pittsburgh, Pa. hereby submits for your review and approval, copies of the above captioned forms. These forms are new and are being filed to replace policy forms

DATE: January 27, 2009

TO: Honorable Jay Bradford, Insurance Commissioner
Arkansas Department of Insurance
SERFF Tracking Number: AGDE-126006318

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V30028AR/V30029AR et al, which were filed and approved by your department on September 12, 2000. Subsequent additions and/or changes were further approved on May 7, 2001, March 31, 2003, May 4, 2004, and February 15, 2005.

The above captioned forms will provide blanket accident and sickness insurance primarily for non-profit emergency service organizations such as volunteer firemen and rescue units, pursuant to 23-86-101 (6) of the Arkansas Insurance Code. Coverage will be provided to eligible residents of Arkansas through an out-of-state policy which has been filed and approved in the state of Delaware on September 3, 2008. Premium is paid by the organization and coverage is provided to all eligible members as defined in the Policy.

These forms are substantially similar to the policy forms being replaced (V30028AR/V30029AR et al) with the most significant change being the issuance of a Policy of Incorporation. The Policy of Incorporation (1) eliminates one of the policies that was being issued; (2) eliminates the need to repeat the same provision shown in both the policy and the summary of coverage; and (3) includes the benefits that have been added and/or amended by amendments since the policy was approved on September 12, 2000.

The Amendatory Endorsement, form number V40006NUFIC, will be used to make changes to the variable information in the Policy, Applications, Summary of Coverages, Riders, and/or Endorsements. Among the various types of changes that may be made through the use of this amendatory endorsement are: (1) changes to benefit limits during a policy period; (2) changes to the mailing address of the organization; (3) adding and optional coverage mid-term; and/or (4) dropping an optional coverage mid-term. The Amendatory Endorsement is considered to be variable in its entirety.

Please note that form numbers V40018NUFIC-AR and V40019NUFIC-AR amend the Summary of Coverages (V4004NUFIC(Rev 01/09) and V40005NUFIC respectively) to comply with your state's statutes as we currently understand them to apply to this type of coverage.

Please note that form number 89644 (7/05) (*Coverage Territory Endorsement*) was approved by your department on June 19, 2007, on a general use basis for all of our companies and for all of our products, current and future. This form is being submitted with this filing only on an "Informational Basis".

Also note that AR-SERVICE INFO (Rev 09/07) is being submitted for informational purposes. This "notice" will be given to insured person if and when they are given a document that explains the benefits.

Unless otherwise informed, we reserve that right to later the layout of the enclosed forms (including sequential ordering of the provisions, color, type face, and font), but will only do so if such change(s) are within the allowable parameters or requirements set forth in you statutes.

We have enclosed a check for the required filing fee and any required filing certification form(s) (including but not necessary limited to the Readability Certification).

Thank you for your consideration of this submission. We look forward to a favorable response. Please feel free to contact me should you have any questions or concerns above this material. You may contact me by

DATE: January 27, 2009

TO: Honorable Jay Bradford, Insurance Commissioner
Arkansas Department of Insurance
SERFF Tracking Number: AGDE-126006318

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writing to me or by telephone. My mailing address, email address, fax number, and telephone numbers are shown under my name.

Very truly yours,



Elaine M. Showstead
Senior A&H Regulatory Affairs Analyst
AIG Commercial Insurance - Law Department
Domestic Accident & Health Division
A&H Regulatory Affairs Unit
Mailstop: PDV1
P. O. Box 667
Wilmington, Delaware 19899-9853
E-mail Address: elaine.showstead@aig.com
Telephone Numbers: 302-594-4683
800-225-5244, Ext. 4683
Fax Number: 302-594-4810